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A Qualitative Case Study of Local Alcohol Policy Implementation in Scotland

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Abstract

Background: Alcohol use is a major risk factor for ill-health and a contributor to health inequalities. Scottish alcohol-related mortality rates are the highest in the UK, with the greatest burden of alcohol-related harm falling on people from the most deprived areas. The Scottish Government has been ambitious in their policy and legislative efforts to address the problem, collectively known as Scotland's 'alcohol strategy'. Although evaluations exist which focus on population-level outcomes and national-level overviews of single aspects of the strategy's implementation, much less is known about how the broad strategy has been implemented at local level. The focus of this thesis is the strategy in place from 2009-2018, which has been recognised internationally for taking a progressive, 'whole population approach' to tackling alcohol-related harm. This thesis explores how local implementation of the alcohol strategy occurred, investigating how the strategy was implemented in practice, and examining challenges facing the local policy actors and partnerships tasked with this implementation work.

Methods: To set the scene for data analysis in this thesis, a systematic review of empirical studies on alcohol policy implementation in high-income contexts was conducted to identify factors affecting local implementation of alcohol policies. The substantive part of the thesis then offers a qualitative, embedded case study of alcohol policy implementation in three purposefully selected local areas of Scotland. Data were generated from semi-structured interviews with nine national-level alcohol policy stakeholders and 54 local alcohol policy implementers (63 interviewees in total). Local interviewees were recruited from two key bodies: (i) Alcohol and Drug Partnerships (ADPs), which are dedicated partnerships tasked with local alcohol policy implementation; and (ii) local Licensing Boards, which are independent regulatory bodies comprised of elected Local Councillors and which preside over the local alcohol licensing system, thus controlling alcohol availability. In order to supplement my understanding about the content of the alcohol strategy, aspects of context, roles of relevant actors, and representations of policy decisions, I also undertook documentary analysis of 16 relevant national policies, legislation, and reports. These included documents comprising the alcohol strategy, as well as supporting guidance or more contextual documents.

Results: The systematic review identified a range of factors that available research suggest influence alcohol policy implementation, and these were grouped into the following three themes: accountability and governance; evidence use; and context and resources. The first two themes directly informed the research questions, while the third is discussed as a cross-cutting theme of the thesis. Multiple accountability relationships within and across ADPs and Licensing Boards were explored using Hupe and Hill's (2007) public accountability typology, refined to capture how local implementers experience multiple 'directional' (vertical top-down, horizontal, and vertical bottom-up) accountabilities. The findings show that, for ADPs, these accountabilities are characterised by complexity, confusion, and miscommunication, with horizontal accountability within ADPs' partnership structures appearing particularly challenging. With regards to Licensing Boards, the findings demonstrate that their current accountability system almost exclusively relies on legal accountability arrangements. This makes Licensing Boards' accountability system distinct from the system for ADPs; the data suggest that these contrasting accountability systems are posing challenges to the implementation of Scotland's alcohol strategy since the system for Licensing Boards does not appear to impose sufficient obligations on Licensing Boards to prioritise public health in their decision-making.

In relation to evidence use, the findings suggest that evidence plays an important but complex role in the implementation of Scotland's alcohol strategy. Drawing on Lorenc and colleagues' (2014) idea of 'cultures of evidence', the data demonstrate that ADPs and Licensing Boards each have a distinct identifiable 'culture of evidence', which is characterised by the varying ways in which actors within these organisations perceive and use evidence. These two cultures of evidence overlapped insofar as members of both organisations reported valuing locally contextualised evidence and each culture was characterised by having a diversity of perspectives within it, reflecting members' diverse professional backgrounds. However, important differences between these two cultures of evidence were also apparent and potentially help explain why ADP members described struggling to influence Licensing Board decision-making. In addition, the findings indicate that evidence constructed in traditional public health settings (e.g. the NHS and universities) was not perceived to be translating well into either ADPs or LBs. Both the accountability issues, outlined above, and the application of 'cultures of

evidence', help explain why seemingly relevant public health evidence may have limited traction within Scottish alcohol policy implementation.

Each of the results chapters also demonstrates the significance of context and resource constraints in shaping implementation. This included impacting on the capacity of ADPs to fulfil national-level expectations, and reinforcing apprehension among LB members about potentially costly appeals against their decisions.

Conclusion: This thesis provides important insights into the implementation of Scotland's national alcohol strategy, demonstrating that accountability, evidence use, context and resources all shape implementation in important ways. Notably, it suggests that effective implementation is being hampered by inadequate governance arrangements in a complex context characterised by a commitment to multi-sectoral collaboration, in which key challenges to partnership working and limited policy coherence are identified.

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1 Introduction to the Thesis

1.1 Introduction

Alcohol use in Scotland is a cause of significant population harms and health inequalities (Beeston et al., 2011). Scottish policymakers have responded to these harms with a policy and legislative approach that has been recognised internationally for its innovation and leadership (Hilton et al., 2014; Trueland, 2016), and variously described as ‘world-leading’, ‘distinctive’ and ‘globally unique’ in policy and research rhetoric (Fitzgerald et al., 2017; Nicholls, 2012; Scottish Government, 2018a). Collectively, this approach is referred to as Scotland’s ‘alcohol strategy’. As will be detailed in Chapter 2, in this thesis the term ‘alcohol strategy’ refers to the collection of policy and legislation in place between 2009-2018, the core of which was the policy *Changing Scotland’s Relationship with Alcohol: A Framework for Action* (Scottish Government, 2009a). The *Framework for Action* was published in 2009 and ‘refreshed’ in 2018 (Scottish Government, 2018a)¹. Outcome evaluations of this strategy suggest that some progress has been made towards reducing alcohol-related harm in Scotland (Beeston et al., 2016). However, alcohol-related harm and demand for services remain high and have recently been rising (Audit Scotland, 2019; Giles and Robinson, 2019).

The Scottish Government’s alcohol strategy is intended to be wide-ranging, addressing alcohol regulation, treatment and harm prevention. However, the past few years have seen substantive policy and political energy directed towards particular national level components of the 2009 strategy. In particular, to the development and enactment of legislation on minimum unit pricing (MUP) of alcohol (arguably the most high profile component of the 2009 strategy) (Katikireddi et al., 2014; Katikireddi and McLean, 2012). The Scottish Parliament passed MUP legislation in 2012, but the Scottish Government was forced to fight a protracted legal battle in European and UK courts against challenges brought by the Scotch Whisky Association (*Scotch Whisky Association and others (Appellants) v The Lord Advocate and another (Respondents) (Scotland)*, 2017). While the Scottish

¹ During the writing up of this research, the Scottish Government was ‘refreshing’ the *Framework for Action*. In November 2018, the government published the ‘*Alcohol Framework 2018*’, which updated the national prevention aims on alcohol, and a joint alcohol and drugs strategy, ‘*Rights, respect and recovery*’ (Scottish Government, 2018a, 2018b).

Government's case was eventually successful and MUP was implemented in May 2018, in the meantime the more local processes of alcohol policy implementation were facing their own challenges. These included increasing levels of alcohol-related harm alongside extensive budget cuts at Scottish local authority level (discussed below and in Chapter 2). Additionally, while MUP continues to be prioritised for policy action² and evaluation (NHS Health Scotland, 2019)³, and a substantial body of research has been undertaken on MUP (e.g. Katikireddi et al., 2014; Katikireddi and Hilton, 2015; Katikireddi and McLean, 2012; McCambridge et al., 2014; O'May et al., 2016; Patterson et al., 2015), a relative dearth of research is available to explain more local processes of alcohol policy implementation.

Given the extent of harms still observed in Scotland (Audit Scotland, 2019), alcohol remains a key public health policy priority (COSLA and Scottish Government, 2018). Since single components of the strategy, such as MUP, are not expected to achieve Scotland's ambitious alcohol-related public health goals, greater understanding of how Scotland's broader alcohol strategy is being implemented locally is required. This thesis takes forward this task, aiming to expand what is already known about alcohol policy implementation in ways that potentially contribute to enabling future alcohol strategies to be more effective in achieving population health goals.

1.2 Alcohol and public health policy in Scotland

From a public health policy perspective, alcohol use presents a complex set of cultural, social, economic, and health characteristics. Globally, while alcohol continues to be used in various contexts for socialisation, faith-based rituals, a gesture of hospitality, etc. (Babor et al., 2010), alcohol remains a cause of major health-related, social, and economic burdens on societies (World Health Organization, 2014a). Whereas some research has suggested that alcohol was only or more harmful when consumed at certain levels (e.g. Baglietto et al., 2006; Zakhari, 1997), or in certain ways (e.g. Mathurin and Deltenre, 2009) the evidence

² At time of writing, MUP remains a key priority for the Scottish Government following publication of the 2018 Alcohol Framework (A Ferguson, personal communication, 13 February 2020).

³ A key reason for ongoing evaluation is the 'sunset clause' in the legislation that means the legislation will expire after six years, unless the Scottish Parliament votes for its continuance (NHS Health Scotland, 2019). The evaluation is necessary to assess the impact of MUP and inform Ministers' and Parliament's ultimate decision (NHS Health Scotland, 2019).

base increasingly suggests that any level of consumption can be harmful (Bagnardi et al., 2013; Connor, 2017). Alcohol consumption is a major risk factor for long-term conditions and a contributor to health inequalities, leading to high rates of population morbidity and mortality (Rehm et al., 2009; World Health Organization, 2014a). For example, the health-related consequences of alcohol use include over 200 conditions, comprising a multitude of non-communicable diseases such as cancer, stroke, and liver disease (Parry et al., 2011; World Health Organization, 2014a). Further, in 2016 approximately 5.2% of all global deaths (approximately 3 million) were attributed to alcohol (GBD 2016 Risk Factors Collaborators, 2017; World Health Organization, 2018).

Consistent with global evidence, relatively high alcohol consumption in Scotland has led to a correspondingly high rate of alcohol-related harms and costs (Beeston et al., 2011). A Scottish Government-commissioned report published in 2010, estimated that alcohol use cost Scotland £3.6 billion in 2007 because of issues such as lost productivity, family breakdown, need for health services, and crime (York Health Economics Consortium, 2010). Subsequent work by Johnston and colleagues (2012), including more 'intangible costs'⁴, estimated the total cost in 2009/2010 to be £7.4 billion. To place this in context, Scotland's GDP⁵ in 2018 was around £163.6 billion (National Statistics Scotland, 2019), suggesting that the annual cost of alcohol exceeds 4.5% of GDP. Comparatively, tobacco is estimated to cost Scotland £1.1 billion per year (ASH Scotland, 2010).

In terms of alcohol-related mortality, Scotland suffers from the highest rates in the UK (Office for National Statistics, 2015). When comparing 2017 statistics with England and Wales, Scottish alcohol-related death rates were twice as high in men and 55% higher in women (Giles & Robinson, 2019). From a peak in early 2000s, data from 2008-2012 suggest that alcohol-related death rates fell (Giles & Robinson, 2019). However, these figures need to be viewed in the context of a longer-term rise and more recent data suggest rates have begun to rise again. In 2017, Scotland's alcohol-related death rates were still 2.5 times higher than they had been in 1981 (Giles & Robinson, 2019).

⁴ Costs which do not yield resources if eliminated, e.g. 'fear of crime'

⁵ 'Onshore' GDP, not adjusted for inflation, excluding oil and gas extraction in Scottish waters.

Placed in a broader health and public policy context, alcohol use is also an important contributor to health inequalities among the Scottish population (Beeston et al., 2011; Katikireddi et al., 2017). Problems related to alcohol use are often intertwined with other social determinants of health, such as experiences of homelessness (Fazel et al., 2008; Ross-Houle et al., 2017), common mental health problems (Conner et al., 2009; Currie et al., 2005; Sullivan et al., 2005); and crime, including intimate partner violence (Foran and O’Leary, 2008; Nutt et al., 2010).

In response to the extent of alcohol-related harms and costs in Scotland, the Scottish Government has been ambitious in their policy and legislative efforts. These efforts include committing to a ‘whole population approach’ in the 2009 *Framework for Action* (an approach maintained in the 2018 Framework ‘refresh’), and including an innovative ‘public health objective’⁶ within alcohol licensing (Alcohol Focus Scotland and SHAAP, 2011; Scottish Government, 2009a). Parties across the political spectrum in Scotland have recognised the issue of alcohol-related harms, and have broadly supported the need for policy intervention (Scottish Parliament, 2015a). This political context is complicated, however, by the constraints of the Scottish devolution settlement. As devolved bodies, the Scottish Parliament and Scottish Government can only act on elements of alcohol regulation which have been devolved to them by the UK Government (Alcohol Focus Scotland, 2017a). Furthermore, some elements of alcohol-related regulation in Scotland take place at the local level, in each of Scotland’s 32 local authorities. These various arrangements are discussed in greater detail in Chapter 2, but it is clear that devolution and the localisation of alcohol policy implementation in Scotland create a complex policy landscape, and that gaps in knowledge remain, particularly about how local implementation has occurred (see Chapter 3).

One of the defining challenges of policy implementation research has been to examine why gaps frequently exist between expectations for a policy’s outcomes and impact, and what is actually delivered and achieved (Hill and Hupe, 2014; Pressman and Wildavsky, 1984). It has long been recognised that, in policy practice,

⁶ A feature which helps differentiate Scotland from England/Wales, where licensing legislation lacks this type of objective (Martineau et al., 2014) (discussed further in Chapters 2 and 3).

if policy implementation is ignored, the desired policy changes will not occur (Pressman and Wildavsky, 1984). Effective enactment of policies into practice remains an endemic challenge and critical concern for stakeholders seeking to improve policy change (Saetren, 2005). If policy implementation is neglected, it makes it very difficult for researchers and policymakers to differentiate between policies that are ineffective because of how they were developed (i.e. their content), or because they have been ineffectively implemented. Indeed, implementation gaps can arise regardless of the quality of the policy's development (Hudson et al., 2019).

The importance of investigating implementation is acknowledged in the field of alcohol policy. For example, a 2017 report on the implementation of the World Health Organization's (WHO) *Global Strategy to Reduce the Harmful Use of Alcohol* noted that progress has been skewed to countries with greater resources to dedicate to implementation, and that further commitment, investment, and coordinated action was required (Jernigan and Trangenstein, 2017). In 2019, WHO ran a consultation regarding the implementation of the Global Strategy, asking stakeholders to reflect on achievements, challenges, and setbacks, demonstrating an international concern with investigating these issues in alcohol policy (WHO, 2019). Responses from Scottish and UK-based organisations reflected key challenges at national levels regarding resources, obstruction from industry, and understanding the priorities of policy decision-makers, as well as locally-specific challenges such as addressing alcohol availability through licensing (Alcohol Focus Scotland, 2019; Institute of Alcohol Studies, 2019).

Although there have been strides towards understanding alcohol use, related harms, and initiatives to combat these in Scotland, research has often focused on single aspects of the Scottish Government's alcohol strategy, such as MUP, alcohol brief interventions (ABIs) or the public health objective within the *Licensing (Scotland) Act 2005* (e.g. Fitzgerald et al., 2015; Katikireddi et al., 2014; MacGregor et al., 2013; Parkes et al., 2011) (see Chapters 2 and 3). However, given the complexity and multi-component nature of Scotland's alcohol strategy, there is a need to investigate the strategy's implementation more broadly. In particular, because local-level actors were positioned by the Scottish Government as being key for implementation (Scottish Government, 2009a), it is important to focus on the local translation and implementation of the strategy.

I first identified this gap in knowledge through my initial readings of Scottish alcohol policy documents, preliminary engagement with existing research, and by undertaking scoping meetings with 11 national and local alcohol policy stakeholders in Scotland (see Chapter 4), from which I gained a greater sense of the complexity of the strategy. For example, I learned that local policy implementers were rarely solely responsible for implementing single components of the strategy but rather worked with a range of relevant organisations, brought together in local partnerships, to collaboratively implement multiple aspects of the strategy. This initial work also helped identify potential knowledge gaps. For example, although existing reports had identified key historical challenges surrounding local partnerships (Audit Scotland, 2009; Cameron, 2007), it remained unknown whether reforms to address these challenges (Scottish Government, 2009b, 2009c) had been successful, suggesting this was an important gap in understanding local governance of Scottish alcohol policy.

This project has therefore been designed to help address gaps in understanding regarding the local dimensions of Scottish alcohol policy. It also seeks to complement an important portfolio of contemporary work, spearheaded by NHS Health Scotland. Following publication of the 2009 *Framework for Action*, the Scottish Government commissioned NHS Health Scotland to establish the taskforce Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) (NHS Health Scotland, 2017a). MESAS was intended to “assess the success of the alcohol strategy” (Beeston et al., 2011, p. 1); the MESAS work portfolio was composed of seven studies, developed collaboratively by stakeholders, which cover a range of licensing, treatment, cultural, and economic topics (NHS Health Scotland, 2014, 2009).

The key objectives of MESAS were to: track implementation progress and reach of key actions; assess extent to which intended outcomes were achieved and were attributable to Scottish Government actions; and identify any unintended outcomes or displacement effects, including those which may impact on health inequalities (Beeston et al., 2011). To achieve these objectives MESAS sought to evaluate measures such as access to services, changes in knowledge about and attitudes to alcohol, economic impacts on the alcohol industry, and changes in alcohol

consumption and related harms (Beeston et al., 2011). Additionally, as will be discussed further in Chapter 2, two MESAS work-streams undertook implementation-related evaluations related to specific components of the strategy - alcohol licensing and ABIs (Beeston et al., 2011).

As a national-level evaluation project, however, MESAS did not examine in detail how the overall alcohol strategy was implemented among different ADPs and local areas in Scotland, leaving a gap in understanding about how the broad national alcohol strategy was being translated, interpreted, and enacted by local level alcohol policy implementers. Having identified this gap early in my research, I conducted informal scoping meetings with members of the MESAS team to ascertain what research focus would be most complementary to their substantial work portfolio – these discussions helped to inform my research design (Chapter 4).

1.3 What This Thesis Will Do

Following on from the above, this thesis will examine the local dimension of alcohol policy implementation in Scotland. It will investigate how key aspects of policy implementation, namely accountability and evidence use, influence the local implementation of Scotland's alcohol strategy, while also paying attention to context and resources as cross-cutting factors. In doing so, it focuses on addressing the overarching research aim of investigating whether and how factors known to shape alcohol policy implementation in high-income settings shaped the local level implementation of Scotland's 2009 alcohol strategy. To achieve this, it answers the following research questions:

1. How was local implementation of Scotland's 2009 alcohol strategy influenced by formal and informal accountability mechanisms in the contexts of:
 - a. Alcohol and Drug Partnerships?; and
 - b. Licensing Boards?
2. What roles (if any) did evidence appear to play in the implementation of Scotland's 2009 alcohol strategy?

Further, the thesis considers how contextual factors and resources appear to shape the local implementation of Scotland's 2009 alcohol strategy, particularly with respect to accountability and evidence-use.

This thesis will first identify research needs for understanding how alcohol policy implementation is undertaken at local-area level. To contribute to addressing these needs, it will then take a qualitative, embedded case study approach (Yin, 2009) to exploring the overarching case of alcohol policy implementation in Scotland. This case will be investigated through (i) analysis of national policy documents which constitute, or were directly relevant to, Scotland's 2009 strategy, (ii) semi-structured interviews with national-level alcohol policy stakeholders, and (iii) semi-structured interviews with alcohol policy implementers (in ADPs and Licensing Boards [LBs]) in three purposely selected 'embedded' Scottish local areas (see Chapter 4).

The findings of this thesis seek to contribute knowledge to the field of alcohol policy implementation by: mapping and elucidating different accountability regimes experienced by local alcohol policy implementers in Scottish ADPs and LBs; exploring how these different organisations perceive and use evidence; and considering the role of context and resources. In doing so, it enhances alcohol policy implementation research by addressing the dearth of research explaining how these factors influence implementation.

This research was conducted during 2014-2019, in the final few years of the 2009 alcohol strategy lifespan. While no claims are made regarding the generalisability of this research, the analysis provides insights into alcohol policy implementation in Scotland at a time when tackling alcohol-related harm was being prioritised. Since concern with alcohol-related harms remains, the findings may be useful for taking forward into the implementation of Scotland's 'refreshed' alcohol strategy (Scottish Government, 2018a, 2018b).

1.4 Thesis Outline

In **Chapter 2**, I map the policy and organisational context of Scottish alcohol policy implementation, introducing key policy, legislation and guidance, and key actors' roles and relationships. **Chapter 3** then presents a systematic review of empirical studies on alcohol policy implementation in high-income contexts. Comprising an analysis of 29 studies, the review identifies three key themes which help explain how implementation occurs, namely (i) accountability and governance, (ii) evidence use, and (iii) context and resources. The results of this chapter help identify

research needs in this field, helping to finalise the thesis research questions and set up the focus of the empirical chapters. **Chapter 4** details the methodological approach, providing an explanation for selecting, and reflections on undertaking, a qualitative embedded case study approach.

The **Preface to the Results** describes the development of my research questions in light of the systematic review and initial data analysis. **Chapter 5** then introduces a typology on public accountabilities by Hupe and Hill (2007) and goes on to examine experiences of accountability reported by ADP members in the context of their implementation work. **Chapter 6**, again using Hupe and Hill (2007) to organise the results, focuses on the different experiences of accountability reported by local LB members. **Chapter 7** focuses on how evidence is perceived and used within ADPs and LBs, identifying that each organisation has a 'culture of evidence' (Lorenc et al., 2014b), and discussing how this appears to influence their work to implement Scotland's alcohol strategy.

Following the empirical chapters, **Chapter 8** provides the discussion chapter of the thesis as a whole, presenting the principal findings and contributions to relevant literature. It also draws together findings from across the three results chapters related to how context and resources influence alcohol policy implementation, in relation to accountability and evidence use. Ultimately, the chapter highlights governance challenges of and multi-sectoral collaboration and partnership and considers implications for future research and practice.

2 Mapping the complex and changing landscape of alcohol policy implementation in Scotland

2.1 Introduction

The purpose of this chapter is to map the complex and changing landscape in which Scotland's 2009 alcohol strategy was being implemented during my research. While historical summaries of Scottish alcohol policy exist (e.g. Butler et al., 2017; Nicholls, 2015), it was important for me (and a potential reader) to understand different aspects of the contemporary policy, legislative, and organisational contexts, so I could be aware of and reflect upon the conditions in which the strategy was implemented in the course of my analysis (Weyrauch et al., 2016). This was important for helping explain how and why implementation occurred in the Scottish environment in the way it did (and recognising that, if similar strategies were implemented elsewhere, implementation and outcomes may be different) (Polit and Beck, 2010). Analysing this within a specific chapter was important because Scottish alcohol policy, and Scottish local policy reform more generally, were in a state of flux during my fieldwork. For example, within the overarching context of Scottish devolution, there was an ongoing, high-profile legal battle regarding MUP (Gillan, 2012), significant cuts to alcohol and drug services funding (Scottish Government, 2015a, 2016a), and challenges interpreting and enacting Scotland's unique 'public health' licensing objective at local level (Fitzgerald et al., 2017). To undertake this mapping I drew from a range of publications, government websites, policy documents and legislation, and informal scoping discussions with 11 stakeholders at national and local levels (see Chapter 4). I also drew on my interview data to add nuance and clarity to this chapter and checked my mapping work with key stakeholders such as Alcohol Focus Scotland.

This chapter first examines Scotland's alcohol policy and legislative landscapes, and introduces the 2009 *Framework for Action* which was core to Scotland's alcohol strategy in the study period. It then discusses the roles of relevant actors and organisations, including a brief analysis of the funding context which was undergoing substantive changes during my fieldwork.

2.2 Scottish Alcohol Policy Landscape

2.2.1 History, Devolution and Alcohol Policy in Scotland

Alcohol-related legislation and policy has a long history in Scotland, in which a mix of politics and culture influenced decision-making (Nicholls, 2012). Scottish magistrates began licensing alcohol in 1756 in response to concerns about alehouses and gin consumption (Nicholls, 2012). Over the next few hundred years, licensing legislation would regulate a variety of issues, including who was permitted to enter licensed premises (based on, for example, age or reputation), opening times of premises, and distinctions between on-sales and off-sales premises (Nicholls, 2012).

More recently, when the Scottish Parliament and Scottish Government⁷ were established in 1999, a number of 'powers' were devolved to this new layer of Government (Devolution (Further Powers) Committee, 2016; Keating, 2010). Several of these powers are relevant to alcohol policy, particularly under the categories of health, law (including the criminal justice and prosecution system), police and prisons (Keating, 2010). These include, for example, competencies to act to regulate alcohol through sales promotions, regulation of the press, printed or billboard advertisements, advertising at sporting events, and sponsorship (Alcohol Focus Scotland, 2017a). Meanwhile, power to restrict alcohol marketing is distributed between the Scottish and UK Parliaments; the UK Parliament retains competence over taxation of alcohol, regulating broadcasting, consumer protection, and internet services (Alcohol Focus Scotland, 2017a). At time of writing, this distribution of powers sits within the broader context of European Union (EU) legislation. For example, while EU law prohibits certain actions which would interfere in cross-border trade within Europe and thus impact market forces, it also states such restrictions can be justified on the grounds of protecting health (Katikireddi and McLean, 2012). This higher level of governance beyond the UK has had implications for Scottish alcohol policy and legislation, most notably during the court challenge against MUP (Katikireddi et al., 2014; Katikireddi and McLean, 2012).

⁷ Up until 2007 the Scottish Government was known as the 'Scottish Executive' (Smith and Hellowell, 2012). This 'rebranding' was done by the new Scottish National Party administration, and was formally changed in law in the *Scotland Act 2012* (UK Parliament, 2012)

Given the devolved nature of health and social care, however, the Scottish Government is generally viewed as responsible for the health and societal costs associated with alcohol-related harms in Scotland. Since devolution, successive Governments have developed policy and legislative responses to these costs and harms⁸. The decisions of different administrations have led to a complicated context, with multiple pieces of legislation and key policies which constitute Scotland's overall 'alcohol strategy' and frame the country's approach to addressing alcohol-related harm (see Box 2.1).

Box 2.1 Key Policy and Legislative Components of Scotland's Alcohol Strategy for the study period (MacGregor et al. (2013); Scottish Parliament (2015c))

- Licensing (Scotland) Act 2005 (enacted 2009)
- Changing Scotland's Relationship with Alcohol: A Framework for Action (2009)
- Alcohol etc. (Scotland) Act 2010
- Criminal Justice and Licensing (Scotland) Act 2010
- Alcohol (Minimum Pricing) (Scotland) Act 2012 (enacted 2018)
- Air Weapons and Licensing (Scotland) Act 2015

Changing Scotland's Relationship with Alcohol: A Framework for Action (Scottish Government, 2009a) was the central pillar of this strategy during my fieldwork. In 2007, the new Scottish National Party (SNP) government explicitly prioritised the issue of Scotland's drinking culture and began developing their national alcohol policy, which became the *Framework* (Nicholls, 2012)⁹. The overall policy was developed with the stated aim of reducing alcohol-related harm and improving the health and wellbeing of Scotland's population (Scottish Government, 2009a)¹⁰. It has been presented as a response to the strong evidence of harms experienced by Scotland's population (McCartney et al., 2011, 2012; Shelton, 2009; Walsh et al., 2010). Proposed actions in the *Framework* reflect an ambitious challenge to the boundaries of Scottish devolution. For example, the pursuit of MUP was an innovative legislative lever to raise the price of cheap alcohol in Scotland despite the

⁸ Scottish Labour Party-Liberal Democrat coalition from 1999 to 2007, followed by a minority SNP government in 2007- 2011, majority SNP government in 2011-2016, and minority SNP government again in 2016-present (Scottish Parliament, n.d.).

⁹ Throughout the research period the SNP was in power, however in 2014 Nicola Sturgeon became First Minister

¹⁰ This included a new NHS target for the delivery of a certain number of alcohol brief interventions in priority areas of primary care, antenatal care, and Accident and Emergency Departments (Scottish Government, 2009a, p. 24)

UK's retained power over alcohol taxation (Gillan and Macnaughton, 2007; Katikireddi et al., 2014).

2.2.2 *The 2009 Framework for Action and Scotland's 'Whole Population Approach'*

A key feature of Scotland's 2009 alcohol strategy was the underlying principle of a 'whole population approach', with accompanying actions targeted at vulnerable populations (Beeston et al., 2011). This approach was based on the principles that: a) a focus on only heavy drinkers neglects a significant portion of the population who are also potentially at risk of alcohol-related harm; and b) an individual's alcohol-related behaviour can be changed by modifying the societal norms of their community and environment (Beeston et al., 2011). This approach can be observed across the strategy's documents (most clearly in the *Framework for Action*).

The *Framework for Action* has been lauded as evidence-informed (Fitzgerald and Angus, 2015), a characterisation aligned with rhetoric around (and public health pressure to achieve) 'evidence-informed policy' across the UK (Greenhalgh and Russell, 2009; Hunter, 2009; Macintyre, 2012). Within the *Framework* document, the whole population approach is presented as reflecting current evidence-informed recommendations for alcohol policy (Babor et al., 2010; Scottish Government, 2009a; World Health Organization, 2010). Comparing evidence-use in alcohol policy across the four UK nations, Fitzgerald and Angus (2015) found Scotland to have the most 'evidence-based approach'. The authors advanced several possible explanations for this, relating to the interplay of evidence and politics. These include the new nationalist SNP government seeking to target a high-profile, national issue which could distinguish Scotland from the UK, and the alcohol industry's relative neglect of the SNP, which meant politicians and civil servants had not been persuaded of industry's positions (Fitzgerald and Angus, 2015). In the context of this previous research, the focus of my thesis is not to understand how the strategy came into being, but to understand how it was implemented.

The *Framework* comprises four action areas (onto which 41 actions are mapped): (i) reduced consumption; (ii) supporting families and communities; (iii) positive attitudes and positive choices; and (iv) improved support and treatment. I conducted an analysis of the full framework, and developed a table of the 41 actions of the

Framework for Action (attached in Appendix 1). In that analysis I interpreted the 'level' at which each action was intended to be implemented (i.e. UK, National [Scotland], Local, or unclear), basing my judgement on how the *Framework* presented each action. For example, where the *Framework* proposed to introduce new legislation or modify existing legislation, this was determined to be at 'national' level. Whereas, where the document states "Work with our partners at national and local level to improve substance misuse education in schools" (Scottish Government, 2009a, p. 15), this was categorised as occurring across both 'national' and 'local' levels. Table 2.1 shows the number of actions I interpreted to be implemented at each level, including those which would need to be acted upon at UK-level.

Table 2.1 Number of policy 'actions' analysed for implementation at different levels of governance

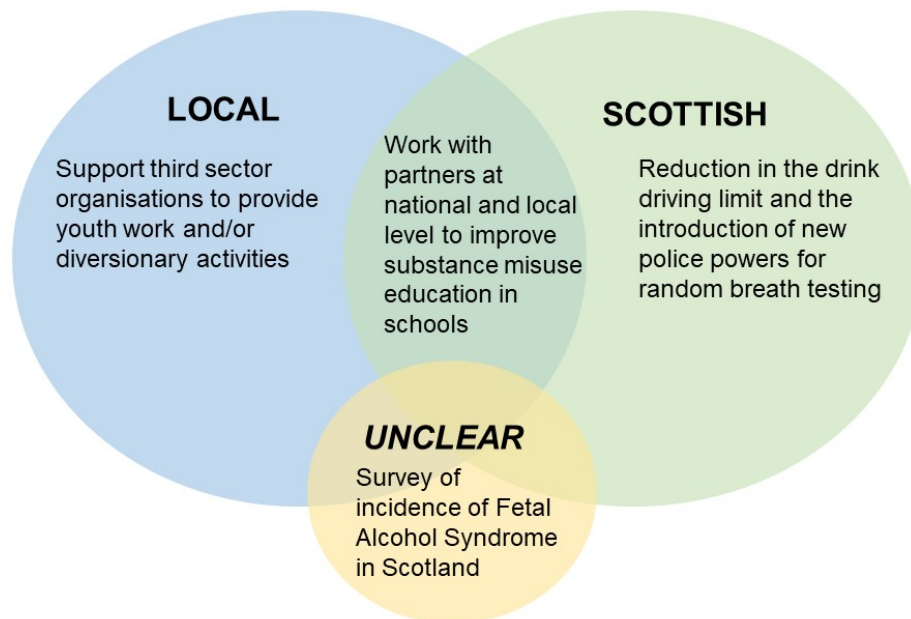
Level	Local	National (Scottish) and Local	National (Scottish)	UK	National (Scottish) and UK	Unclear
Number of Actions	8	11	8	3	1	9
*Total adds to 40, because one 'action' was a decision "not to introduce alcohol only checkouts" and was therefore not implemented						

The actions within the *Framework* I interpreted as needing to be implemented primarily at local level often related to service provision, education, and health promotion. This analysis exercise showed me that while certain components of the strategy have a relatively clear locus of responsibility, others are more ambiguous and require interpretation by stakeholders. This lack of clarity about where responsibility lies for policy components has important implications for accountability, an issue explored in the empirical chapters¹¹.

Figure 2.1 illustrates this analysis, indicating types of actions that I interpreted from the framework as being enacted at each level. For the figure I selected examples from across the 'supporting families and communities' action area because it provided a range of actions across local and national (Scottish) level, particularly ones which were later discussed by my interviewees as priorities and were thus relevant to my analysis.

¹¹ Note, the 'refreshed' Alcohol Framework 2018, in the Summary of Actions (p. 4-7), does identify which organisation(s) are responsible for each action (Scottish Government, 2018a).

Figure 2.1 Analysis of Level at which Framework for Action Locates Implementation Responsibilities for Proposed Actions ('Supporting Families and Communities') (Scottish Government, 2009)



2.2.3 Broader Policy and Legislative Landscape

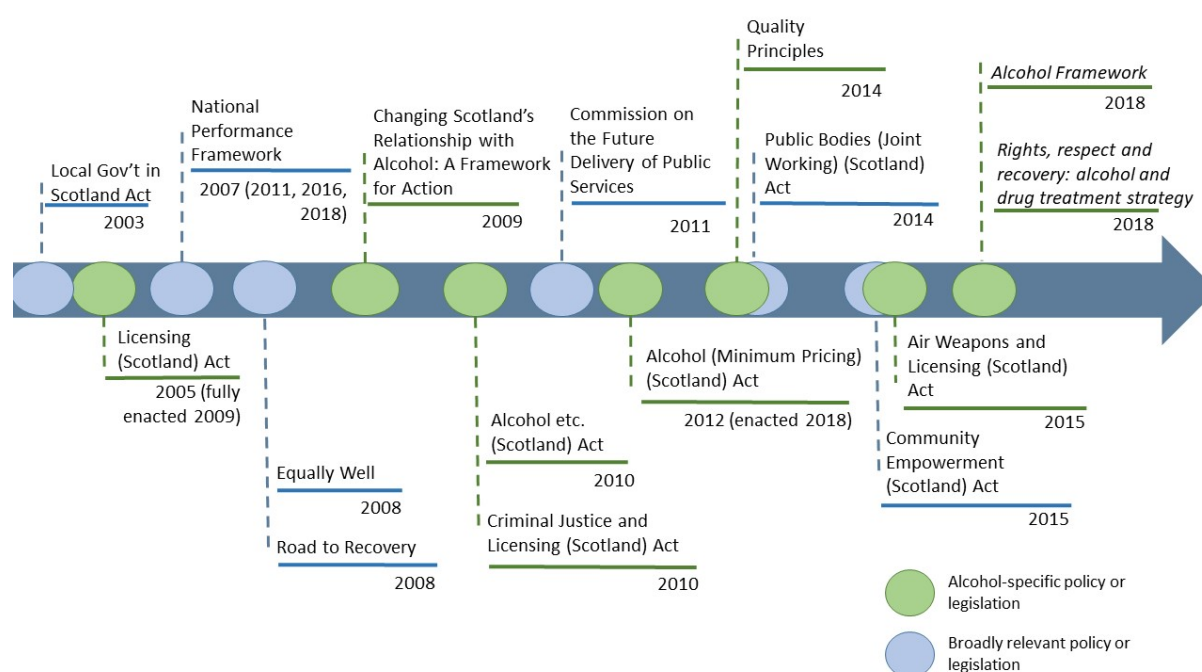
A number of broader policies, legislation, and other government documents helped to shape the political and policy context in which the 2009 alcohol strategy was implemented. Figure 2.2 provides a timeline which includes: a) policy and legislation explicitly focused on alcohol (denoted with green dots), and b) policies and legislation which are relevant to alcohol policy (blue dots). This timeline has been updated to include the Scottish Government's newly published, 'refreshed' alcohol policy strategy documents which were published after the fieldwork and analysis had been undertaken for this research. The timeline excludes policies or legislation prior to 2005 which are no longer in place and which were not discussed in my data¹².

The Scottish Government's parallel drug misuse strategy, '*The Road to Recovery: a new approach to tackling Scotland's drug problem*', was published in May 2008 and is an example of a related, but not alcohol-specific policy (Scottish Government,

¹² For example, Scotland's first post-devolution alcohol strategy from 2002, the '*Plan for Action on Alcohol Problems*' (Katikireddi et al., 2014).

2008a). Given the remit of ADPs to address both drug and alcohol use, this policy is a key component of the alcohol policy environment at local level. The drug strategy focused primarily on reforming drug services to be ‘recovery-oriented’ and more strongly emphasising the achievement of outcomes (Scottish Government, 2008a). However, drug policy was not a focus of this research, and at the time of my fieldwork this was a separate strategy from the *Framework for Action*. Therefore, I made the decision to not examine the drugs strategy further in this thesis (though, since the most recent, ‘refreshed’ alcohol strategy for Scotland has been combined with drugs, future research would require a different approach).

Figure 2.2 Timeline of Alcohol-Specific and Related Policies and Legislation (2003-2019)



The Scottish Government's *National Performance Framework* (NPF) sets out a common vision for all public services in Scotland (Scottish Government, 2015b). Originally published in 2007 and updated regularly (Scottish Government, 2016b, 2018c), the NPF provides a range of measures to monitor progress in relation to the Government's 'Purpose', 'Values' and national outcomes, including pursuing a Scotland in which 'we are healthy and active' (Scottish Government, 2018d). Population harms from alcohol present a challenge to the achievement of NPF objectives. Previous iterations of the NPF which were relevant to my study period

(‘refreshes’ in 2011 and 2016) included an alcohol-specific National Indicator to “reduce alcohol-related hospital admissions” (Scottish Government, 2017a)¹³. The NPF has also indicated important linkages can and should be made across Scotland’s public service sector in order to achieve identified goals for Scotland (Scottish Government, 2014a).

2.3 Legislative Landscape

2.3.1 Alcohol Legislation

Multiple laws have been enacted to regulate alcohol licensing in Scotland (see Box 2.2). The *Licensing (Scotland) Act 2005* and its’ statutory objectives have their roots in the 1973 ‘Clayson’ Committee on Scottish licensing law, with the resulting report calling for major changes to the licensing system (Nicholls, 2012). Overall, the report recommended changes which would establish greater accountability, and “foreshadowed the principle of licensing objectives enshrined in the 2005 Licensing Act” (Nicholls 2012, p.1401). Further, it led to the development of the *Licensing (Scotland) Act 1976* which established LBs. In 2003, the ‘Nicholson Committee’ published a comprehensive review of Scottish licensing legislation (Scottish Executive, 2003), the recommendations of which then formed the basis for the current *Licensing Act 2005* (enacted in 2009). Importantly, this included recommending the establishment of licensing objectives, providing greater scope for LBs to restrict alcohol availability in the public interest (MacNaughton and Gillan, 2011).

Details of the public health objective and Licensing Policy Statements established by the *Licensing Act 2005* are provided in Section 2.5. The other legislation listed makes amendments to the *Licensing Act 2005* and other existing legislation. For example, the *Alcohol etc. (Scotland) Act 2010* restricts certain drinks promotions based on the quantity purchased (e.g. buy one, get one free) for off-sales, and requires that Health Boards become statutory consultees to the LB. The *Air*

¹³ The most recent (2018) version of the NPF identifies ‘health risk behaviours’ as a key relevant indicator, which measures the percentage of adults with two or more health risk behaviours (smoking, harmful drinking, low physical activity, etc.) (Scottish Government, 2018e).

Weapons and Licensing (Scotland) Act 2015 mandates LBs publish annual reports on their functions, including a summary of decisions.

Box 2.2 Scottish alcohol licensing legislation 2005-2019

Licensing (Scotland) Act 2005

- Came into full effect in late 2009 after transition period
- Makes provision for regulating the sale of alcohol, and the premises on which alcohol is sold
- Contains five licensing objectives:
 - Preventing crime and disorder;
 - Securing public safety;
 - Preventing public nuisance;
 - Protecting and improving public health; and
 - Protecting children from harm.
- Places duty on Licensing Boards to produce a Licensing Policy Statement every three years

Alcohol etc. (Scotland) Act 2010

- Enacted October 2011, introduced new mandatory licensing conditions.
- Makes provision for regulating sale of alcohol and licensing of premises, including extending ban on quantity discounts for off-sales
- Introduced requirement for Licensing Boards to consult with relevant Health Board when preparing their Licensing Policy Statement and notify Health Board of all premises license applications.
- “Signals a retraction of liberalising trends of previous decades” (MacNaughton & Gillan, 2011, p. 23)

Criminal Justice and Licensing (Scotland) Act 2010

- Relevant components aimed to improve enactment of Licensing Act by modifying number of provisions and ensuring Licensing Boards have adequate information for license decision-making.

Alcohol (Minimum Pricing) (Scotland) Act 2012 (MUP)*

- Enacted 1st May 2018
- Amends aspects of the Licensing (Scotland) Act 2005 and Alcohol etc. (Scotland) Act 2010
- Mandates that alcohol must not be sold below a minimum price per unit, set by the Scottish Government at 50p per unit of alcohol

Air Weapons and Licensing (Scotland) Act 2015

- Lengthens the lifespan of Licensing Policy Statements to four years;
- Mandates Licensing Boards submit annual financial and functions reports

Sources: MacGregor et al., 2013; MacNaughton and Gillan, 2011; Scottish Parliament, 2015b, 2012, 2011, 2010, 2005

* While MUP had not been enacted at the time of my data collection, and was not a focus of the analysis (see Chapter 1) it is included here for completeness.

In addition to legislation which explicitly regulates alcohol, other legislation has the potential to influence alcohol policy implementation. For example, during this research alcohol policy implementers were navigating new changes to local governance caused by the enactment of the *Public Bodies (Joint Working) (Scotland) Act 2014* (Scottish Parliament, 2014a). This Act mandated Health Boards and local authorities integrate their governance, planning and resourcing of adult social care and key health services (Burgess, 2016, p. 5). This was relevant to my research because responsibility for local alcohol policy implementation was shared across NHS, local authority, and other key actors who were adapting to these new requirements of integrated working.

Additionally, the *Community Empowerment (Scotland) Act 2015* promotes public participation in policy decision-making (Scottish Government, 2017b; Scottish Parliament, 2015b) and was in the process of enactment during my fieldwork. It served as a relevant part of the alcohol policy implementation context during this research.

2.4 Key Stakeholders

The complexity of alcohol policy implementation in Scotland is also reflected in the diversity of organisations and actors involved. Figure 2.3 provides a quick overview guide of key actors involved in alcohol policy implementation and where they are 'located' in terms of local and national governance levels as of 2017. They include government, third-sector, private sector, and people in communities, and demonstrates the complicated, multi-level landscape in which implementation occurs. Although not depicted here, it is important to note the relationships these actors have with one another (exploring certain aspects of these is a focus of the results chapters).

Figure 2.3 Scottish Alcohol Policy Organisational Landscape (as of 2017)



The Scottish Parliament is a unicameral, committee-based legislature - committees carry out inquiries and make recommendations to Parliament (Scottish Parliament, 2014b). The primary committee for Scotland's alcohol strategy is the Health and Sport Parliamentary Committee (Scottish Parliament, n.d.). The Committee's remit is to scrutinise government policy and legislation, therefore they have a role in interrogating the content and delivery of alcohol-related policy and legislation. The topic of alcohol also cuts across other committees' remits, however, further illustrating the complex context of alcohol policy. These include a Cross-Party Group on Drug and Alcohol Misuse (Scottish Parliament, 2019a); a Cross-Party Group on 'Improving Scotland's Health: 2021 and Beyond' (Scottish Parliament, 2019b); and the Local Government and Communities Committee (which has responsibility for alcohol licensing, and has led the Parliament's inquiries into updating the statutory guidance for alcohol licensing) (Scottish Parliament, 2019c) .

Within the Scottish Government, the Alcohol Policy Team was responsible for developing the *Framework for Action* in the lead-up to its publication in 2009. Following departmental reorganisation in 2016, during my research the Alcohol Policy Team and Substance Misuse Unit were both responsible for different components of Scotland's overall strategy towards alcohol use. For example, while the Alcohol Team led the refresh of the *Framework for Action*, the Substance Misuse Unit was responsible for treatment and recovery support for both alcohol and drugs, and in undertaking this, ran a support team for local ADPs and has responsibility for setting ADP priorities (National Level Interviewee 7). Ministerial

responsibility for this portfolio was transferred from Justice to Health during budget planning for 2016-17 (Kleinberg, 2016).

2.4.1 Scottish Government Information Organisations

Linked to the Scottish Government are a number of public organisations which provide research on, and data and evaluations for, alcohol-related indicators, this helping measure aspects of the extent and outcomes of alcohol policy implementation¹⁴. While these public organisations work at national level in Scotland, they often use data provided by local authorities and health boards, providing a local level connection.

Information Services Division (ISD) Scotland provides health information to support quality improvement in health care (ISD Scotland, 2010a). It has a 'Health & Social Care Drug & Alcohol Team' which produces and collates information regarding alcohol indicators, for the purposes of supporting monitoring of the national strategy and for decision-making about alcohol treatment services (ISD Scotland, 2010b).

The Scottish Public Health Observatory (ScotPHO) is a collaboration between ISD Scotland, NHS Health Scotland (discussed below), and a range of other public health partners who aim to improve collection and routine use of data on health-related issues and determinants (Scottish Public Health Observatory, 2017).

ScotPHO curates a website which provides key data sources, as well as overviews and reports. Their work is coordinated by a steering group constituted of government, public health, and academic actors (Scottish Public Health Observatory, 2017).

NHS Health Scotland is a national health board which provides evidence to support the reduction of health inequalities, supports the use of this evidence in practice, and evaluates health interventions (NHS Health Scotland, 2017b). NHS Health Scotland supports the delivery of the *Framework for Action*, for example by providing guidance for delivering ABIs (NHS Health Scotland, 2017c). ABIs are

¹⁴ On 1st April 2020 the Scottish Government and Convention of Scottish Local Authorities (COSLA) will establish a new national public health body, Public Health Scotland, which will bring together the organisations discussed (COSLA and Scottish Government, 2019)

structured, talk-based counselling sessions which seek to help an individual reduce their drinking behaviour (Kaner and O'Donnell, 2013). In 2010, NHS Health Scotland was also tasked with evaluating Scotland's alcohol strategy through MESAS. When developing my own research, I conducted exploratory, informal 'scoping' interviews (see Appendix 2 and Chapter 4) with two MESAS researchers to discuss how my own research could best complement this work.

The MESAS work portfolio was developed collaboratively by stakeholders (NHS Health Scotland, 2014, 2009) and undertaken between 2010-2015. The MESAS team published annual reports describing the progress and results of these studies, with a final report published in 2016 (Beeston et al., 2016)¹⁵. The portfolio includes seven separate studies, of which two were particularly relevant to this research: (i) MacGregor and colleagues' (2013) study of the implementation of the *Licensing (Scotland) Act 2005*, in which they assessed whether the Act had been implemented as intended; and (ii) Parkes and colleagues' (2011) study which assessed the implementation of ABIs delivered in certain NHS settings in Scotland. Greater detail about these studies and their findings are included in the systematic review in Chapter 3.

2.4.2 Local Authorities and Community Planning Partnerships

Actors at local level are relevant to the implementation of Scotland's 2009 alcohol strategy because they influence strategic decision-making about local priorities and have a role supporting alcohol policy implementation. There are 32 Local Authorities; each is governed by a local Council which is comprised of elected Councillors and functions autonomously from central government (but within existing legislation and the Government's NPF) (Scottish Government, 2015c). Local Authorities are responsible for providing services such as education, social care, and cultural services to their constituency (Scottish Government, 2015c). Local Authorities are represented nationally by the Convention of Scottish Local Authorities (COSLA), which lobbies the Scottish Government on their behalf (COSLA, n.d.).

¹⁵ Routine monitoring continues, however, and MESAS is currently leading the evaluation of MUP (NHS Health Scotland, 2017a).

Correspondingly, there are also 32 Community Planning Partnerships (CPPs) in Scotland's local areas, of which the Local Authority is a leading partner. 'Community planning' is the collaborative working of public services and communities to design and deliver services locally, with partnerships between public services and their communities to identify and address local needs (Scottish Government, 2019a). Community planning was originally established through the *Local Government in Scotland Act 2003*, however this was developed further by the *Community Empowerment Act 2015* (Scottish Government, 2017c). The *Community Empowerment Act 2015* increases the number of public sector organisations who must be involved in community planning (Scottish Government, 2016c). Despite this legislative change, research suggests improvement is still needed to consistently prioritise the involvement of communities in planning and delivery of services (Audit Scotland, 2018; Weakley and Escobar, 2018). This was relevant to my research because I became interested in whether and how communities, through potential accountability mechanisms, might influence aspects of local alcohol policy implementation.

CPPs are responsible for developing and delivering a Local Outcomes Improvement Plan which determines key outcomes for the local area and the strategy for how to achieve them (Scottish Government, 2019a). Local Outcomes Improvement Plans replaced Single Outcome Agreements; agreements that were made between each CPP and the Scottish Government and described how the local area would provide public services according to the unique needs of their local contexts. The *Community Empowerment Act 2015* mandates CPPs contribute resources towards securing participation of community bodies throughout community planning (Scottish Government, 2019a). Community planning is part of the local framework in which alcohol policy implementers are working, and ADPs (discussed below) are formally accountable for reporting to CPPs (Scottish Government, 2018f) (see Chapter 5).

Alcohol and Drug Partnerships

There are currently 30 ADPs in Scotland. They are key local partnerships tasked with undertaking the local implementation of Scotland's alcohol policy, and are a key organisation in this thesis. Such partnerships have existed in some form since 1989 – for example, from the early 2000's these partnerships were known as 'Alcohol and Drug Action Teams' (ADATs) (Audit Scotland, 2009) until a Stocktake report of their

performance recommended a shift to 'Alcohol and Drug Partnerships' (Cameron, 2007). This Stocktake considered whether partnership was the right approach for combating substance misuse in Scotland, evaluated whether ADATs were the best model for this, and considered what might work better. The chair of the Stocktake, Sandy Cameron CBE, concluded that "a partnership approach was essential" (Cameron, 2007, p. 4), but highlighted numerous ways ADATs could be improved. Relevant observations included the need for "greater clarity about what is expected of them and by whom" (p.5) and that "[ADATs'] lines of accountability are not always clear" (p. 32). Further, that "the lines of accountability and reporting were varied", but that "around half [of ADATs] saw their accountability as being three fold: i) to the Scottish Executive; ii) collectively through the other ADAT partners and iii) ultimately to local citizens and service users." (p. 32). This three-fold accountability is relevant for my analysis in Chapter 5 of ADPs' reported experiences of multiple accountabilities.

A series of recommendations were included in the 2007 Stocktake, which are again relevant for this thesis because they speak to issues of accountability and evidence use. This includes, for example, that ADATs should be directly accountable to Ministers and there should be "better use of analytical expertise at local and national levels" (Cameron, 2007, p. 9).

Similar challenges to those observed in the Stocktake were noted by Audit Scotland in 2009 (Audit Scotland, 2009). With regards to governance of local partnerships for alcohol and drug services, their report noted that "a lack of central guidance has led to variation in how local partnerships operate", and that the "roles and responsibilities of drug and alcohol partnerships are still unclear" (Audit Scotland, 2009, p. 28).

Following publication of the Stocktake and Audit Scotland reports, Scottish Ministers established a joint group to consider what reforms may be required, specifically considering how to clarify responsibilities and accountability arrangements, develop an outcomes toolkit regarding substance misuse services, and recommend how national support coordinators could support work to combat substance misuse (Scottish Government, 2009b). This was followed in 2009 by the publication of *Delivering Better Outcomes: An Outcomes Toolkit for Alcohol and Drugs*

Partnerships (Scottish Government, 2009b) and a *New Framework for Local Partnerships on Alcohol and Drugs* (Scottish Government, 2009c); the latter established ADPs¹⁶. Having taken forward certain recommendations from the 2007 Stocktake, these reforms saw ADPs retain the partnership-working structure of ADATs, and begin developing Annual Strategic and Delivery Plans, as well as Annual Reports to Scottish Government. The critique in the Stocktake and Audit Scotland report provide an opportunity to examine continuity and change in the policy context in the era of ADPs; these are reflected on in Chapter 8.

In the time-period during which I was undertaking this research, ADPs have been expected to “commission evidence-based, person-centred and recovery-focused treatment services to meet the needs of their resident populations” (Scottish Government, 2017d), and in doing so, act as key organisations for the local implementation of Scotland’s alcohol strategy. In fulfilling these expectations, ADPs must develop local strategies “based on the identification, pursuit, and achievement of agreed local outcomes, and supported by the development of a local outcomes framework” (Scottish Government, 2009c, p. 4). These local ADP Strategies are agreed on by the ADP members, and are supported by a Delivery Plan (Scottish Government, 2009c).

Each ADP is supported by a small administrative team, which is embedded in the local health and social care governance arrangements (either as Council or NHS employees) and have a rotating Chair from a member organisation. Member organisations represent a range of public bodies. These can include, but are not limited to, health, police, community justice, social work, and education (Scottish Government, 2009c). ADPs also have representation from the third sector, although existing guidance does not specify how this should be structured. In the three local areas included in this research, just one individual from a third sector organisation had been selected to sit on each ADP.

In terms of national-local interactions, the Scottish Government provides support to ADPs in the form of funding and guidance (COSLA et al., 2015). ADPs are expected to report to the Scottish Government about their activities - they are monitored

¹⁶ Note, both documents are included in the empirical analysis in this research, along with the *Framework for Action*, also published that same year - see Chapter 4

through the use of national targets, indicators, and outcomes (COSLA et al., 2015). Intended ADP core outcomes are listed in Box 2.3 below. Additionally, ADP strategies are “subject to scrutiny” from other bodies, including the Care Commission (Scottish Government, 2009c).

Box 2.3 Intended Core Outcomes for Alcohol and Drug Partnerships (Scottish Government, 2013)

1. **Health:** People are healthier and experience fewer risks as a result of alcohol and drug use.
2. **Prevalence:** Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others.
3. **Recovery:** Individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use.
4. **Families:** Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances.
5. **Community safety:** Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour.
6. **Local environment:** People live in positive, health-promoting local environments where alcohol and drugs are less readily available.
7. **Services:** Alcohol and drugs prevention, treatment and support services are high-quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery.

Although the Scottish alcohol strategy is constituted of a range of legislation and policy, and responsibility for enacting these may be viewed as diffuse, in terms of the local implementation of this national strategy, ADPs are where responsibility for local implementation comes together. For example, policy documents (e.g. COSLA et al., 2015; Scottish Government, 2009c) suggested the Scottish Government expected ADPs to play a key role at the local governance level to plan, organise, and ensure delivery of alcohol and drugs services, and my informal scoping interviews also suggested ADPs were critical to understanding how Scotland’s alcohol strategy was implemented locally.

As a multi-stakeholder partnership, they bring together a variety of organisations, service providers, and stakeholders who have responsibility for, or concern with, different aspects of the strategy’s ‘whole population approach’. Therefore, the focus on ADPs also allowed me to examine perspectives from multiple organisations and to appraise how they work together to implement Scottish alcohol policy. For example, although an NHS Health Board may be viewed as a key, local organisation responsible for implementing alcohol policy, focusing on this one organisation would

neglect other, broader, social determinants of health-related aspects of policy implementation.

Funding for Alcohol and Drug Partnerships

Funding for ADPs' alcohol policy implementation work is provided to local areas by the Scottish Government. To fund the work of ADPs, national-level interviewees in this research reported the Scottish Government pays a given amount to the local Health Board, who acts as 'banker' for the ADP, which as a non-statutory body cannot hold funds itself. The Health Board then provides the ADP with these funds as needed. This system has implications for implementing alcohol policy initiatives locally, an issue discussed in Chapter 5.

The draft Scottish Government budget in December 2015 announced ADP funding would be transferred from the Justice Department to Health and Wellbeing (Smith, 2017). Further, that the combined drug and alcohol funding for ADPs was being cut by approximately 22% - a total budget decrease across Scotland from £69.21 million to £53.8 million (Scottish Government, 2016a, 2015a). Health Boards across Scotland were informed they were expected to make up this difference in funding from their own budgets. A Freedom of Information (FOI) request by the Scottish Conservatives in early 2016 showed seven of the 14 health boards did not make up this shortfall for their ADPs in their geographical catchment area (Scottish Conservatives, 2017)^{17,18}. Significant concern over the cuts have been expressed, including from ADPs themselves (e.g. Dumfries and Galloway ADP, 2016) and other stakeholders such as AFS (Alcohol Focus Scotland, 2017b).

The introduction of these budget cuts was occurring during my fieldwork, and in interviews participants remained uncertain as to whether their local Health Boards would be covering the shortfall. This aspect of the financial context provided an opportunity to explore some of the existing tensions in the financial infrastructure of alcohol policy funding in Scotland. During this time it was too early to adequately assess the effect of the cuts on service user populations, however media articles from 2017 (citing opposition political parties) have been quick to connect the cuts

¹⁷ I have chosen not to specify whether the ADPs examined in this research experienced budget cuts for reasons of anonymity.

¹⁸ Also confirmed later in an Audit Scotland (2019) report (p. 17).

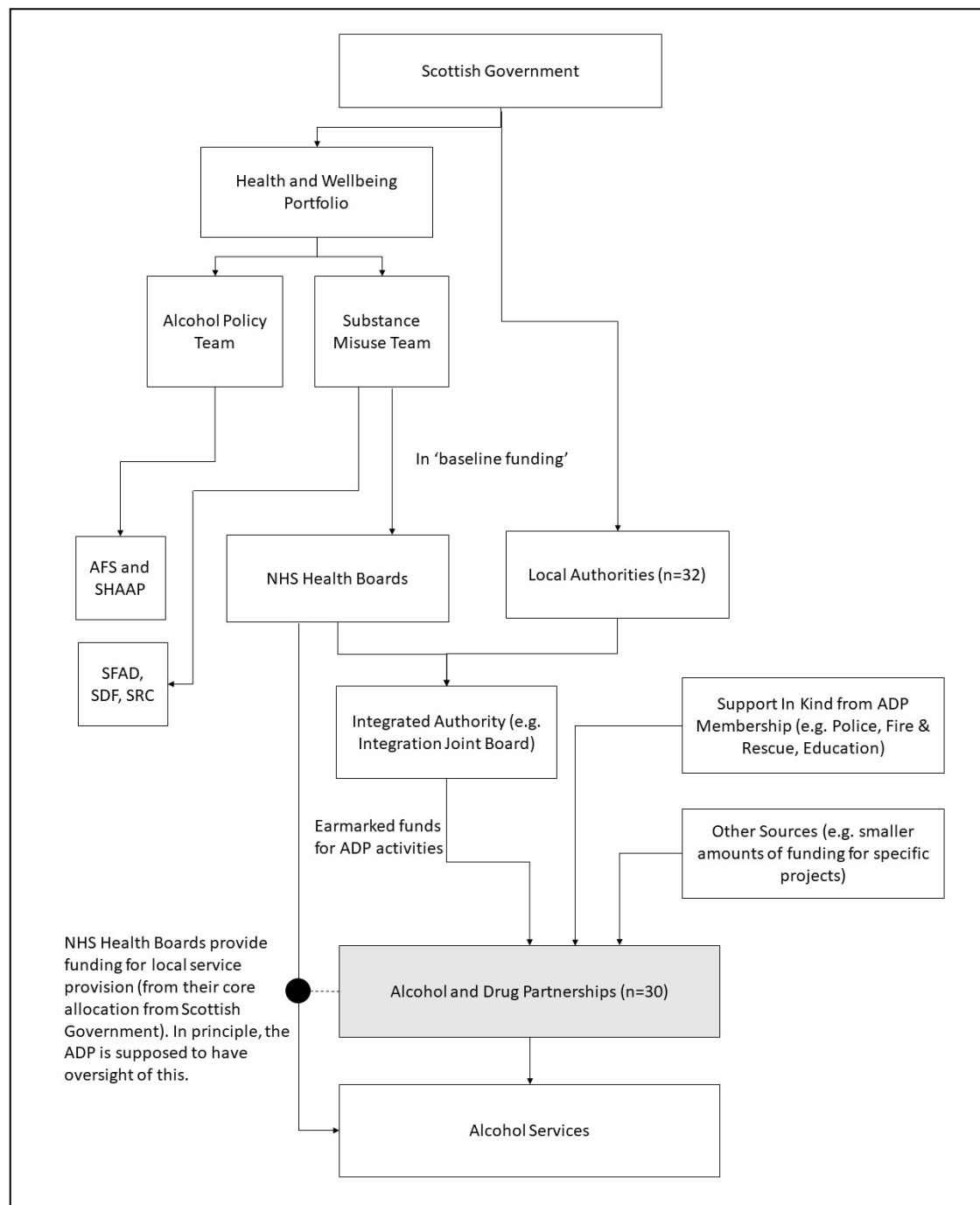
with observations of increased mortality from alcohol and drugs (e.g. Bunting, 2017; “Shock over rise in drug deaths,” 2017).

The changes in funding levels were made in parallel to changes in funding governance for alcohol services. I developed Figure 2.4 below to depict the funding arrangements for ADPs following the changes in 2017, the purpose of which was to map, and make sense of, the sources of funding for ADPs. A similar figure had previously been published by Audit Scotland (2009) on all spending for alcohol and drug services. The need to undertake this exercise became clear during my data generation, during which my interviewees reported that they were working in a complex and often ambiguous funding context, which had implications for how they worked to implement Scotland’s alcohol strategy. For example, a key change which is reflected in the figure was the Scottish Government’s transfer of funding for ADPs to NHS Boards as part of their ‘baseline budget’, and the delegation of ADP funding and functions locally to Integration Authorities (Kleinberg, 2017a). These changes have implications for accountability because subsuming addictions budgets within, for example, a Health Board’s broader budget, makes it more difficult to trace the path of the funding.

I developed the figure using information available from a combination of sources, including Government, specific ADPs’ reports or meeting minutes, information from research interviews, and feedback from key stakeholders at national and local level. The figure excludes funding which is not directed to ADPs. For example, an additional investment of £20 million in alcohol and drugs was announced in the Scottish Government’s published programme for 2017-18 (Scottish Government, 2017e), and then provided the next financial year (2018-2019, after my study period). However, neither the programme or correspondence with national and local level stakeholders during my data generation suggested it would be distributed to ADPs¹⁹.

¹⁹ Since that time, this funding has been specified in the refreshed (and combined) alcohol and drugs strategy as a commitment of “£20 million per year until 2021 in treatment and support services” (Scottish Government, 2018b, p. 6). The total amount has been split between three funding streams - the Local Improvement Fund, National Development Project Fund, and Substance Use Challenge Fund, some of which goes to ADPs. However, much of the funding is focused specifically on drugs services (A Adams, personal communication, 14 February 2020).

Figure 2.4 General ADP Funding System as of 2017



2.5 Scottish Licensing System

2.5.1 Licensing Boards

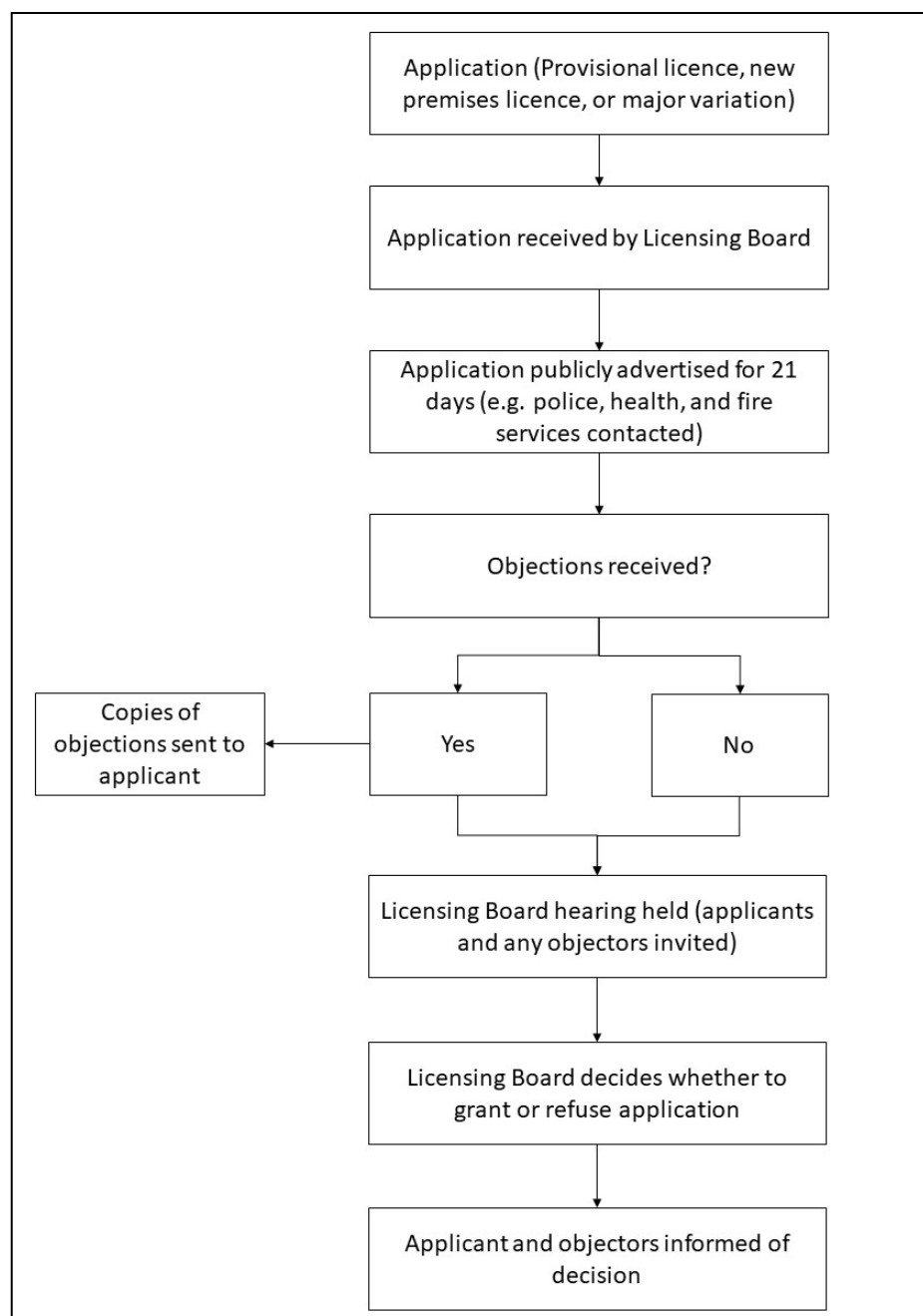
LBs exist in each Local Authority area of Scotland, and are comprised of locally elected Councillors. LBs preside over the local licensing system – they are

independent regulatory bodies responsible for decision-making about alcohol licensing (Scottish Government, 2017f).

In the context of local government, Councils and their respective Councillors have a certain level of autonomy from the Scottish Government. This is grounded in the Concordat signed by the Scottish Government in 2007 with COSLA, which removed certain controls that Government had over Councils (Scottish Government, 2007). This has implications for the role of Councillors in alcohol policy implementation, since their status as Councillors means they are not automatically obligated to follow Scottish Government-identified priorities (e.g. to commit to a whole population approach to tackling alcohol-related harm). However, this autonomy is complicated by two further factors. First is the Government's parallel implementation of the NPF. As part of the aforementioned Concordat, local governments have to identify their local priorities through community planning and demonstrate how these contribute to the NPF (through Local Outcomes Improvement Plans) (Scottish Government, 2007). Consequently, Councillors involved in alcohol licensing appear to be subject to possible tensions between their relative autonomy as locally elected officials and the mandate for local areas to contribute to the NPF. Second, as quasi-judicial entities, LBs are not accountable to the local Council; distinguishing them from local political/policy-making committees which have corresponding scrutiny committees and decisions can be referred to the Full Council (Cllr L Young 2018, personal communication, 6 May). This effectively makes them separate from community planning (although they are meant to have regard to community planning alongside other national and local policies/strategies). I return to this issue in Chapter 6 when discussing LB accountability.

LBs convene monthly, in a public forum, to decide whether to grant or reject personal and premises alcohol license applications. Applicants submit their applications in advance; at the meeting LB members may call upon applicants (who are often present with a legal representative) to answer questions about their application. Decisions to grant or reject the application are often made on the spot, although some are deferred if the applicant is not present or if LB members wish to make a 'site visit' to the proposed premises. A flow-chart of this process, developed by Alcohol Focus Scotland (2016a), is shown in Figure 2.5.

Figure 2.5 Alcohol Licence Application Decision Process (Source: (Alcohol Focus Scotland, 2016a)



The Public Health Objective in Scottish Alcohol Licensing

LBs are required to work towards the licensing objectives as stated in the *Licensing (Scotland) Act 2005* (see Box 2.1). The *Licensing Act 2005* established five licensing objectives. Within these, the ‘public health objective’ is particularly important for this research; it mandates that LB members be concerned with protecting and improving public health. The public health objective gives LBs a duty to assess the number

and density of licensed premises in their area. Premises density is a key measure if one is concerned with alcohol availability and its impact on health outcomes – a link which has been demonstrated in the Scottish context (Richardson et al., 2015). It is important to note that the *Licensing Act 2005* constituted a significant shift and expansion of LBs functions as they had been originally conceptualised (MacNaughton and Gillan, 2011). Later legislation has worked towards enabling this somewhat, for example the *Alcohol etc. (Scotland) Act 2010* established Health Boards as a statutory consultee. It has been recommended by Alcohol Focus Scotland, however, that this set of legislation be synthesised into one comprehensive Act (MacNaughton and Gillan, 2011).

The public health objective responds to international evidence suggesting easier availability of alcohol (e.g. as measured by the number of licensed premises for on- or off-sales) in a given local area leads to higher levels of harm (e.g. World Health Organization, 2014a). This objective also distinguishes Scotland from the rest of the UK²⁰ and countries globally, in that it enshrines into legislation that reducing alcohol availability is a key component of the Scottish Government's strategy to reduce alcohol-related harm (Fitzgerald et al., 2017; Scottish Government, 2008a). It is also consistent with the aims of other components of Scotland's alcohol strategy. For example, the *Framework for Action* (Scottish Government, 2009a) included a stated intention to monitor the effectiveness of measures meant to control the availability of alcohol. As another example, the Scottish Government states that alcohol availability is an influencing factor for alcohol-related hospital admissions (a key national performance indicator) (Scottish Government, 2016d). The importance of reducing availability of alcohol to achieve national policy goals, and the mandate for LBs to consider public health, means LBs and their members are key actors for alcohol policy implementation in Scotland. Based on the powerful position LBs hold locally, from a public health perspective, licensing is important for reducing alcohol-related harm via the public health objective.

²⁰ Alcohol licensing legislation in England and Wales does not have a 'public health objective' to mandate that licensing decisions be made with consideration of public health (Martineau et al., 2014). It has been argued that this lack of a public health objective constrains the ability of public health advocates to influence licensing decisions, forcing them to pursue their goals by making arguments that links alcohol outlet density to issues like alcohol-related crime and anti-social behaviour (Martineau et al., 2014).

Licensing Policy Statements and “Overprovision”

The primary way the public health objective is embedded in LBs’ regular decision-making is through Licensing Policy Statements. LBs are required to publish Policy Statements every four years, aligned with local election cycles (Scottish Parliament, 2015c). When making their licensing decisions, LBs must make them in consideration of the content of their Policy Statement (Alcohol Focus Scotland, 2014a). As per the *Licensing (Scotland) Act 2005*, each LB must develop and publish a Licensing Policy Statement that has regard to relevant legislation and statutory guidance. This includes stating how the LB will progress towards each of the five licensing objectives. However, it has been noted that LBs do have significant discretion surrounding the details and substance of the Policy Statement (Alcohol Focus Scotland, 2014a; Scottish Executive, 2007). MacNaughton and Gillan (2011) assessed that the introduction of Policy Statements,

“represent[ed] a sea change in the way Licensing Boards operate, shifting licensing from being an application-driven process to a policy-driven one. Licensing decisions are now obliged to have a policy context and a stated policy position can be used as grounds to refuse an application for a licence.” (p.23)

Within their Policy Statement and with respect to the public health objective, the LB must also lay out their ‘overprovision statement’ for the local area. The term ‘overprovision’ refers to an “assessment that there are too many licensed premises in a particular locality either in terms of the number of premises, the capacity of premises, the type of premises, or the size of a display area” (MacGregor et al., 2013, p. vi). The *Licensing (Scotland) Act 2005* mandates that the LB “include a statement [within their Policy Statement] as to the extent to which the LB considers there to be overprovision” of licensed premises in their area (Scottish Executive, 2007, p. 5). This is labelled as their “duty to assess overprovision” (Scottish Executive, 2007, p. 5). By distinguishing a given area as overprovided for, LBs have policy grounds to refuse new license applications in this area.

Despite the articulation of the concept of ‘overprovision’, existing evidence suggests the public health objective has been very difficult to enact (Fitzgerald et al., 2017; MacGregor et al., 2013). In their evaluation of the implementation of the *Licensing Act 2005*, MacGregor and colleagues (2013) found that full implementation of the public health objective was problematic for numerous reasons. This included that it

lacked an adequate working definition or guidance for enacting it, and links between the health and licensing sectors continue to be fraught with misunderstandings about each other's agendas. In response to these challenges, MacGregor and colleagues (2013) emphasised the need for more, and better, guidance for LBs about how to address this objective. These challenges are discussed further in Chapters 3 and 6.

2.5.2 Other Licensing Stakeholders

Licensing Standards Officers are locally-appointed individuals who work to liaise between the LB, Local Licensing Forum (discussed below) and licensees. They support the enactment of the *Licensing Act 2005*, providing licensees with information and guidance about their responsibilities and monitoring compliance with these responsibilities (MacGregor et al., 2013). Licensing Standards Officers attend the meetings of their local LB (as a consultee), but are not a key focus of this thesis because their remit is about supporting licensing legislation only and they do not have policy decision-making authority.

Local Licensing Forums are locally formed groups which are mandated by the *Licensing Act 2005* to “keep under review the operation of the licensing system in their area and to give advice and recommendations to the Licensing Board.” (Scottish Executive, 2007, p. 73). In turn, the LB must “have regard” to the recommendations of the Local Licensing Forum, and where it decides not to act on those recommendations, must provide reasons for not doing so (Scottish Executive, 2007, p. 73). Their members must include a Licensing Standards Officer and a representative from the local Health Board. Other members are likely to include representatives from a range of other stakeholders, e.g. holders of alcohol licenses or residents of the local area (Alcohol Focus Scotland, n.d.; Scottish Executive, 2007). The relationship between Local Licensing Forums and LBs is discussed in Chapter 6 from an accountability perspective.

2.6 Other Stakeholders

Beyond national and local government, a range of other stakeholders are involved in the governance surrounding Scotland's alcohol strategy. For example, it has been shown that representatives of the public health community in Scotland were highly

influential in the prioritisation of alcohol on the political agenda and the subsequent development and implementation of the strategy itself (Holden and Hawkins, 2012).

2.6.1 Voluntary Sector

Alcohol Focus Scotland

Alcohol Focus Scotland (AFS) is a national charity, with a stated mission of supporting the prevention and reduction of alcohol-related harm (Alcohol Focus Scotland, 2017c). Through their work, AFS seeks to promote “effective and cost-effective action to reduce consumption” (Alcohol Focus Scotland, n.d., p. 2). Established in the 1970s to support Local Councils, AFS is funded by the Scottish Government, grants, and self-generated income, and does not accept funding from industry (Alcohol Focus Scotland, 2017c). AFS is a key public health stakeholder; they were mentioned frequently in my interviews with both local and national alcohol policy stakeholders. AFS also frequently partners with other public health organisations such as Scottish Health Action on Alcohol Problems and BMA Scotland (Alcohol Focus Scotland, 2017c).

AFS has conducted extensive work related to alcohol licensing in Scotland. This includes hosting licensing-related events (Alcohol Focus Scotland, 2016a), publishing a review of Licensing Policy Statements (Alcohol Focus Scotland, 2014a), and developing a Community Licensing Toolkit to support members of the public to engage with the licensing system (Alcohol Focus Scotland, 2016a). AFS is also a key provider of mandatory training for new LB members, the content of which is determined by the Scottish Government (Alcohol Focus Scotland, 2017d).

Scottish Health Action on Alcohol Problems

In 2006 the Scottish Medical Royal Colleges created Scottish Health Action on Alcohol Problems (SHAAP), for the purpose of providing medical and clinical advocacy about evidence-informed approaches to reducing alcohol-related harm (SHAAP, n.d.). SHAAP is funded through a Scottish Government grant, and their stated aims are to: raise awareness and understanding of alcohol-related health problems; evaluate current research and identify evidence-based strategies to reduce alcohol-related harm; and work with key organisations to tackle alcohol use (SHAAP, n.d.)

2.6.2 Alcohol Industry

In contrast to the individual organisations highlighted in the subsection above, the alcohol industry is a broad group of actors who share profit-related concerns. Alcohol industry stakeholders include global, national and local alcohol producers (Casswell, 2013), collective organisations established and funded by these producers (e.g. the Scotch Whisky Association²¹), importers of alcohol, and on- and off-sale retailers such as pubs and supermarkets, respectively (Alcohol and Public Policy Group, 2010). This diverse group of actors is sometimes divided in their perspective on certain issues – for example, while the Scotch Whisky Association led the court challenge against MUP legislation, other industry actors such as a pub retailer and brewers supported the legislation, citing concerns about the availability of strong, cheap alcohol (O’Leary, 2017).

Estimated public sector revenue from alcohol duties in Scotland was £1,038 million for 2016-17, accounting for 2.0% of total revenue for Scotland (Scottish Government, 2017g). Alcohol production and sales contribute to the Scottish economy and employment (Holden and Hawkins, 2012). In the *Framework for Action*, the Scottish Government notes the integral role of alcohol in Scottish life and industry, and “welcomes this positive aspect of [Scotland’s] relationship with alcohol” (Scottish Government, 2009a, p. 6). This suggests a potential conflict of interest; it is clear that the Government wishes to maintain the revenues and jobs that result from the alcohol industry, while also implementing a strategy to reduce alcohol-related harms.

The actions of industry and resultant revenue for Scotland are linked to the Government’s overarching purpose and aims. During my study period, the NPF stated the Government’s overarching ‘Purpose’ was to create a flourishing Scotland “through increasing sustainable economic growth”, while health was included as a

²¹ The Scotch Whisky Association is the trade body for the Scotch whisky industry (Scotch Whisky Association, n.d.). It has over 70 member companies, and is governed by an elected Council of its members (Scotch Whisky Association, n.d.). seeks to support “the best possible global business environment for Scotch Whisky”, which includes challenging regulation and taxes, as well as maintaining “constructive relationships” with governments (Scotch Whisky Association, n.d.).

lower 'Strategic Objective' (Scottish Government, 2017h). The composition of this critical policy may have signalled the prioritisation of economic concerns over public health ones²².

In her ministerial foreword of the *Framework for Action*, Nicola Sturgeon stated that the industry has "crucial parts to play in helping to develop and implement what will be a rolling programme of work over the coming months and years" (Scottish Government, 2009a, p. 4)²³. Thus the role of industry during the period studied in this thesis was enshrined in existing Scottish alcohol policy. This is relevant for this thesis because it helps perpetuate pervasive discourses about the importance of the economy which, as will be discussed in Chapter 6, prioritise economic growth over concerns about costs from alcohol-related harm. Additionally, there remains evidence of industry presence in policy spaces in Scotland. For example, the Scottish Parliament convenes a Cross-Party Group on Scotch Whisky²⁴, in which the alcohol industry, as per the description of the group, continues to pursue status as a legitimate partner in "tackling alcohol misuse" in Scotland. (Scottish Parliament, 2019d).

2.7 Conclusion

This chapter has mapped and briefly analysed the complex and changing policy, legislative, organisational, and economic landscapes in which Scotland's 2009 alcohol strategy was implemented. This exercise was crucial for my understanding of the contexts in which I was conducting my research, and for orienting readers to the relevant strategy and organisations discussed in my analysis (Chapters 5-8).

²² As of 2019, the current Government Purpose appears to place these concerns on more equal footing, stated as: "To focus on creating a more successful country with opportunities for all of Scotland to flourish through increased wellbeing, and sustainable and inclusive economic growth" (Scottish Government, 2018d).

²³ The new *Alcohol Framework 2018* takes a stronger stance, stating: "The Scottish Government will not work with the alcohol industry on health policy development..." (Scottish Government, 2018a, p. 9).

²⁴ The UK Parliament in Westminster also convenes an All-Party Parliamentary Group on Scotch Whisky, with the Scotch Whisky Association again acting as the group's secretariat. At time of writing, the Chair and Secretary of the Group are both Members of Parliament for the Scottish National Party (House of Commons, 2019).

In this chapter I have also begun to identify potential ambiguities and challenges (e.g. with interpreting and enacting legislation, and resource constraints) in Scottish alcohol policy implementation. In particular, this chapter has identified ADPs as multi-sectoral partnerships embedded in complex, dynamic local governance contexts, and that LBs are important quasi-judicial actors whose decisions have implications for alcohol availability and, consequently, related harms. These actors and their implementation work will be the focus of my analysis in this thesis.

The next chapter turns to the relevant academic literature, presenting a systematic review of empirical studies about local implementation of alcohol policy – this serves to further situate my research in the field of alcohol policy implementation and helps to inform my choice of themes for my empirical analysis.

3 Alcohol Policy Implementation in High-Income Countries: A Systematic Review of Empirical Studies

3.1 Introduction

This chapter aims to provide insights into how national alcohol policies have been implemented locally and identify key factors which help shape implementation. It presents a systematic review of relevant qualitative, quantitative, and mixed-methods literature in high-income settings, examining two key issues:

1. What is currently known from empirical studies about how national-level alcohol policies in high-income settings have been implemented, and why implementation occurred as it did?
2. Are there any identifiable gaps, tensions or uncertainties in knowledge regarding the above?

In addressing these questions, the overarching purpose of this chapter is to inform the empirical work of this thesis and position the thesis within the alcohol policy implementation literature.

Alcohol policies are developed and implemented at a variety of policy levels (Babor et al., 2010; Hadfield et al., 2009a; World Health Organization, 2010), and their impact has been variable (Hadfield et al., 2009b; Mooney et al., 2017; Parkes et al., 2011). Available literature draws attention to some of the challenges of implementing national alcohol policy (Butler, 2009) but I am not aware of any reviews explicitly and systematically assessing what is known about how national alcohol policies are implemented locally and why implementation occurs the way it does²⁵. This underlines the value of this chapter, the findings from which inform the resulting analytical work in this thesis²⁶.

For the purposes of this review and my empirical analysis across the thesis, I have drawn upon O'Toole's definition of policy implementation:

“Policy implementation is what develops between the establishment of an apparent intention on the part of government

²⁵ And none were found during the current systematic review

²⁶ The systematic review was undertaken after initial analysis and presentation of my empirical data. See Preface to Results for more detail.

to do something, or to stop something, and the ultimate impact in the world of action.” (O’Toole, 2000, p. 266).

This definition was useful because, in the broader thesis I sought to analyse how Scottish alcohol policy implementation was being enacted between the Government’s establishment of its’ 2009 alcohol strategy and the resultant policy outcomes²⁷. It meant I did not look at the way the policy was developed nor did I seek to evaluate its outcomes – I wanted to know what happened *between* these. This also helped me focus the present systematic review – I excluded studies which exclusively examined how a policy was developed or evaluated policy outcomes, instead focusing on the dynamic aspects of how policies were being interpreted, translated, and implemented. Given the flexibility of this definition, it also allowed me to conceptualise policy implementation broadly, including incorporating the more contemporary understanding of implementation as ‘governance’, and I included ‘governance’ as a keyword in my search strings (see section 3.2.1).

This review was informed by a literature review on health policy implementation I conducted for an earlier version of this chapter (undertaken prior to data generation). The earlier chapter version enabled me to identify potential themes for data extraction in this systematic review (and helped inform my data generation, e.g. interview questions). The earlier chapter version, and this current systematic review, were also informed by a review I conducted for the Scottish Parliament as part of a placement during my PhD (Wright, 2017; Appendix 3). The review for Parliament attempted to identify key messages about health policy implementation which would be useful for Parliamentarians who develop and scrutinise legislation. In contrast, this chapter takes a systematic review approach to reviewing studies specifically focused on alcohol policy implementation, to understand key factors which influence implementation.

The next section describes the methods I used to conduct this review. I then present the findings, which are organised into topic categories. Finally, the discussion

²⁷ A common difficulty in developing a definition of policy implementation is deciding whether it should describe *outcomes* (i.e. examining an end-state to assess whether policy implementation has occurred, and to what extent the outcomes match the expectations), or should describe the continuing *process* of implementation (deLeon, 1999; Lane, 1987; O’Toole, 1995). Given that this thesis seeks to contribute knowledge about how Scottish alcohol policy implementation was occurring, it subscribes to the latter approach.

outlines the key themes generated from this review and their implications for my analysis (in particular the focus of my results chapters) and broader alcohol policy research.

3.2 Systematic Review Methods

This systematic review was informed by relevant methodological literature on systematic reviewing (e.g. Boaz et al., 2002; Lavis et al., 2005; Misra and Agarwal, 2018; Papaioannou et al., 2010; Petticrew and Roberts, 2006), and was guided by the PRISMA systematic review checklist (Liberati et al., 2009; Moher et al., 2009), the completed version of which is in Appendix 4. This review was registered in March 2019 with PROSPERO: CRD42019124477.

3.2.1 Search Strategy

Relevant databases were identified by: (i) utilising the list of Social Science databases on the University of Edinburgh's Library website, (ii) reviewing the academic databases employed in existing alcohol-related literature reviews (e.g. Fitzgerald et al., 2016; Martineau et al., 2013; Savell, et al., 2016), and (iii) reading about social sciences databases (Aghaei Chadegani et al., 2013). I also discussed and confirmed my chosen databases with the social sciences librarians at the University of Edinburgh.

I ultimately included: IBSS, Social Science Database (ProQuest), PsycInfo (Ovid), PubMed, ScienceDirect, Scopus, and Web of Science. I chose these databases because they effectively captured public health policy research, but also provided the opportunity to capture potentially relevant research from other social science disciplines (for example, Scopus and Web of Science are two of the largest interdisciplinary, relevant databases (Aghaei Chadegani et al., 2013)). I considered and decided to exclude additional 'child databases' from Ovid, namely Embase and MEDLINE (whose searches resulted in multiple pharmacological and biomedical publications of limited relevance), and Global Health. This latter database was excluded because its limited results (n=127) were mainly duplicates of those returned from PsycInfo, and by scanning titles I assessed that non-duplicate results were not relevant.

The search strings were developed iteratively, and searches were conducted in two rounds (Table 3.1). Round 1 sought to identify publications with a focus on alcohol policy implementation, using keywords (and their variants) including 'alcohol', 'policy', 'implementation', and 'governance'. Round 2 sought to identify publications focused on implementation of particular, common approaches within alcohol policy for tackling alcohol-related harm, which included marketing, pricing, and licensing/availability of alcohol - those which are also captured by WHO's 'Best Buys' (World Economic Forum and World Health Organization, 2011) and which are commonly discussed in literature and policy documents (Chisholm et al., 2018). This additional round seemed necessary after importing results, removing duplicates and commencing screening from Round 1. In the course of this work, I reflected that I had potentially not captured publications that discuss specific components of national strategies, e.g. 'licensing' or 'marketing', and which may not have used 'policy' in their title or abstract. To address this risk, and avoiding the need to rerun full searching and screening again, I decided to run a second round of searches and combine the two.

Search strings were tailored to each database to cast a sufficiently wide net while reducing the possibility of attaining biomedical-focused results. Searches were conducted in November 2018 and did not include any date restrictions. As per PRISMA guidelines (Moher et al., 2009), I have below reported on the full search string for one database (PubMed – selected to show the types of restrictions I included in databases that had greater topical breadth). The full searches for all databases are reported in Appendix 5.

Table 3.1 Round 1 and 2 Search Strings

Database	Search String (* indicates a truncation of the word to include all forms of that word)
PubMed	Round 1 ((((alcohol[Title/Abstract]) AND (policy[Title/Abstract] OR policies[Title/Abstract] OR regulat*[Title/Abstract] OR legislat*[Title/Abstract])) AND (implementation OR governance)) AND Humans[Mesh])) NOT (medicine[Title] OR oncology[Title] OR cancer[Title] OR pharmacology[Title] OR biotechnology[Title] OR forensic[Title] OR transplant*[Title] OR diagnostic[Title] OR genetic*[Title] OR dental[Title] OR dentist*[Title] OR infection[Title] OR agricultur*[Title] OR neurolog*[Title] OR surgery[Title] OR pediatric*[Title] OR pharmaceut*[Title] OR laboratory[Title])
	Round 2 (((((((alcohol[Title/Abstract]) AND (availability[Title/Abstract] OR licens*[Title/Abstract] OR marketing[Title/Abstract] OR price[Title/Abstract] OR affordability[Title/Abstract]) AND (implementing[All Fields] OR implementation[All Fields]) NOT (medicine[Title] OR oncology[Title] OR cancer[Title] OR pharmacology[Title] OR biotechnology[Title] OR forensic[Title] OR transplant*[Title] OR diagnostic[Title] OR genetic*[Title] OR dental[Title] OR dentist*[Title] OR infection[Title] OR agricultur*[Title] OR neurolog*[Title] OR surgery[Title] OR pediatric*[Title] OR pharmaceut*[Title] OR laboratory[Title])) AND Humans[Mesh])))

Systematic reviews seek to take a comprehensive approach in their capture of relevant literature (Boaz et al., 2002), and grey literature is often an important source of knowledge to contextualise or fill gaps in peer-reviewed research (Adams et al., 2017). In this review, I searched three grey literature databases: (i) OpenGrey (includes grey literature from social science and other potentially relevant areas of scholarship), (ii) Grey Literature Report (includes literature in health services research and other selected health topics), and (iii) National Bureau of Economic Research (NBER) Working Papers. For these searches I adapted the search strings for the peer-reviewed databases. However, given the limited returned results I also widened my searches in these databases (e.g. searching for ‘alcohol’ AND ‘policy’, without any other restrictions), to check whether I needed to use different keywords. This did not result in any additional relevant results. Finally, I conducted a Google Scholar search for the same period, again using keywords ‘alcohol policy’ and ‘implementation’. While no relevant results were returned from the grey literature

databases, Google searches and pre-existing knowledge of relevant publications (e.g. MacGregor et al., 2013) led to three inclusions.

3.2.2 Inclusion and Exclusion Criteria

Included publications were limited to empirical studies (either peer-reviewed or grey literature), excluding purely theory or discussion-based studies. This decision was informed by the focus of the research on understanding alcohol policy implementation in practice. The inclusion and exclusion criteria are listed in Box 3.1.

Box 3.1 Systematic Review Inclusion and Exclusion Criteria

Publications were included if they:

- Reported on the process of implementing a national or regional alcohol policy, including if:
 - a regional alcohol policy is examined within a context where regions have devolved responsibility for developing and implementing alcohol policy [e.g. Scotland within the UK, or provinces in Canada];
 - alcohol is discussed in combination with drug, mental health, or wider non-communicable disease policy (as long as alcohol is given a primary role in the discussion); AND
- were empirical, published studies (peer-reviewed journal article or grey literature); AND
- discussed a high-income context; AND
- were written in English.

Publications were excluded if they met any of the following:

- Focused on:
 - Implementation of alcohol interventions intended to change behaviour;
 - Development or design of an alcohol policy;
 - Measurement/counting of whether a given alcohol policy had been implemented in a particular context, and/or focused solely on the measured 'strength' of the alcohol policy;
 - Effectiveness or outcomes of alcohol interventions or single programmes;
 - Health effects of alcohol consumption;
 - Non-governmental alcohol policies (e.g. policies developed and/or implemented by schools, universities, workplaces, sports clubs, etc.);OR
- were not empirical; OR
- did not discuss a high-income context; OR
- were written in a language other than English.

This review was intended to investigate current understanding of whether and how alcohol policies have been implemented. I therefore wanted to exclude publications

that focused on, for example, the development or design of an alcohol policy, or the implementation of a more individual-level intervention, project, or clinical treatment (e.g. for individuals already experiencing alcohol-related harm). I sought to include empirical studies regarding policies or legislation which had been developed at national or (devolved) regional level. I characterised these as being intended to have population-level effects, and which, to be implemented, required public officials to translate, interpret, and enact the policies locally, within the context of the existing policy system. For example, a significant body of work regarding ABIs exists which primarily relates to their clinical delivery to individuals in primary care settings by practitioners (NICE, 2010), but this type of study was excluded because the current review seeks to capture implementation of population-level policies. Studies which were concerned with ABIs as a component of a national alcohol policy or strategy, for example how they might be effectively coordinated, funded, or monitored (e.g. Fitzgerald et al., 2015; Parkes et al., 2011) were included in this review. Accordingly, I excluded publications concerned with: the health effects of alcohol consumption and alcohol interventions that were intended to change behaviour; policies that did not originate in a government setting (e.g. policies developed and/or implemented by schools, universities, workplaces, sports clubs, etc.); or measuring the outcomes of alcohol interventions or single programmes.

Publications were also limited to high-income countries (or studies which included at least one high-income country), because the purpose of this review was to inform my research in the (high-income) Scottish context. I felt it was appropriate to exclude low- and middle-income settings because they typically operate within radically different policy contexts from high-income ones (Court and Cotterrell, 2006; Gilson et al., 2018). I acknowledge, of course, that there can be meaningful contextual differences across high-income contexts.

3.2.3 Screening and Decision-making

After searching each database, I imported all resultant citations into Endnote X9 reference manager and then removed any duplicates. Titles, abstracts, and full texts were screened for relevance in a stepped manner.

I acknowledge that decisions were necessarily somewhat subjective. When uncertain about whether to include a particular study on the basis of my defined

criteria, I discussed this with my supervisors until a consensus was reached. This happened for three publications: Hadfield and Measham (2015), which I had reservations about due to a combination of public and industry funding²⁸, was ultimately included but the funding source is highlighted in the analysis. I was cautious about including industry-funded research because of concerns about industry's vested interests in outcomes of research (McCambridge and Mialon, 2018) and the conflict of interest this introduces to the research process (Babor, 2009; Dyer, 2018). Two other articles (Jones-Webb et al., 2014; Mosher and Treffers, 2013) were excluded because I assessed they did not report on the implementation of a national- (or otherwise centrally-developed) alcohol policy.

Where multiple publications appeared to report on the same dataset, I decided to treat each as individual studies, since their foci were sufficiently different to contribute distinct insights to the problem of alcohol policy implementation. However, where a grey literature and a peer-reviewed study reported on the same analysis, only the peer-reviewed study was included. This was to avoid including multiple versions of the same study, which could exaggerate the evidence supporting a particular finding. This occurred in two instances, leading to the exclusion of a report by Thom and colleagues (2011) on partnerships (which was covered by Thom et al., 2013) and a report by Hadfield, Lister, & Traynor (2009a) on integration of local and national alcohol policy (covered by Hadfield et al., 2009b). Among the included journal articles, it appeared that two sets of articles drew from the same, or partially the same, data corpus (1. Fitzgerald et al., 2017 and 2018; and 2. Lloyd et al., 2014; Thom et al., 2013; Toner et al., 2014).

I reviewed reference lists of included texts and identified three further studies (Foster, 2016; Foster et al., 2007; Hadfield et al., 2009b). The Foster (2016) and Foster et al. (2007) publications appear not to have been picked up by the search strings because they are grey literature publications (while I did search three grey literature databases, such databases are known not to be comprehensive). The Hadfield et al. (2009b) publication did not include the keyword 'implementation' in its

²⁸ The article was partly funded by Portman Group, which is an organisation established by the alcohol industry (Portman Group, 2017) and has been critiqued for its role in maintaining self-regulation of industry (Alcohol Concern, 2018).

title or abstract and therefore would have also been missed by the search string, despite having a clear implementation focus in the main text.

The final list of studies was discussed with my PhD supervisors and an external researcher (Dr Joanna Reynolds, Sheffield Hallam University) who was leading an NIHR-funded research project on 'exploring community engagement in local alcohol decision-making' and has expertise in the area of local alcohol policy. No additional publications were identified via these discussions.

3.2.4 Analysis

Included studies were imported into a data extraction matrix in Microsoft Excel. The categories for data extraction combined standard systematic review fields (e.g. publication, funding source, aims, context, methods and data sources) with categories that I had identified in earlier scoping work. These included: resources, actors/institutions, partnerships, processes/practices, networks, multi-level communication, accountability, community engagement, uses of evidence, and 'other barriers' and 'other facilitators' to implementation. After data extraction, on weight of evidence I analysed that five factors were important for reporting in the results: performance measurement, partnership or collaborative working, public involvement, resources, and evidence use. I report these in a narrative way (Grant and Booth, 2009) in Section 3.3.2. From these results, key explanatory were generated and are discussed in Section 3.4.

Quality Assessment

Reflecting standard practice in systematic reviews, I appraised included studies for quality (Siegfried and Parry, 2019). I drew on the framework developed by Hawker and colleagues (2002), which I selected for its flexibility in guiding the appraisal of studies with varied methodologies (including qualitative approaches) and because a structured approach has been acknowledged as increasing transparency in assessments (Dixon-Woods et al., 2007). The framework includes nine categories for which an assessment is made: abstract and title; introduction and aim; method and data; sampling; data analysis; ethics and bias; results; transferability or generalizability; implications and usefulness). Each is rated from 'Good' (4 points) to 'Very Poor' (1 point), with Hawker and colleagues (2002) providing descriptions for

each rating. Following Hawker and colleagues' guidance, and other reviews utilising this approach (e.g. Lorenc et al., 2014), I used these ratings to report a single summary score: High Quality [30-36]; Intermediate Quality [24-29]; or Low Quality [9-23]. I recorded the ratings for each included study in an Excel spreadsheet, and report the summary score in Table 3.2 (see Appendix 6 for full breakdown for each study).

Reflecting on my use of this framework, one limitation was its omission of considerations of theory within the articles, which is used in some other frameworks for assessing the quality of qualitative studies (Harden et al., 1999; Noyes and Popay, 2007). Another consideration was that certain categories had some overlap (e.g. methods/data and sampling). Additionally, while the framework is discussed by the authors as appropriate for assessing both qualitative and quantitative research, the inclusion of 'transferability or generalisability' as a criterion is in contrast with an interpretive understanding of the purpose and contextuality of qualitative research. I therefore modified my interpretation of this criterion to assess qualitative research studies in terms of whether they had plausible 'lessons' which could be potentially considered for other contexts, so as not to automatically penalise these articles with a low generalisability score. Inevitably, these 'ratings' remain subjective.

Consistent with the approach applied in my previously published systematic review of public health taxes (Wright, Smith, & Hellowell, 2017), I did not exclude studies on the basis of quality. I took this approach because of the diversity of included studies and the difficulty in setting clear criteria and thresholds by which I would exclude qualitative research (Reynolds et al., 2011), combined with my concern about excluding potentially useful studies. Instead, as a basis for inclusion, I made my own assessment (guided by my chosen framework) as to the quality of the findings and their relevance to my topic. Consequently, I have chosen to discuss the quality appraisal within the interpretation of the results.

3.3 Results

This section first discusses the bibliographic results of the literature search, and then presents the results generated from data extraction, analysis and synthesis. As noted above, these results are presented for categories that were discussed most

often (and in greatest depth) in the included studies as factors that influence alcohol policy implementation.

3.3.1 Bibliographic results of literature search

A total of 25 peer-reviewed journal articles and four grey literature studies (for a total of 29 studies) were included and analysed. Figure 3.1 below depicts the study flow diagram for this review, while Table 3.2 summarises the full list of included studies.

Figure 3.1 Study flow diagram for literature search, article screening and article inclusion/exclusion

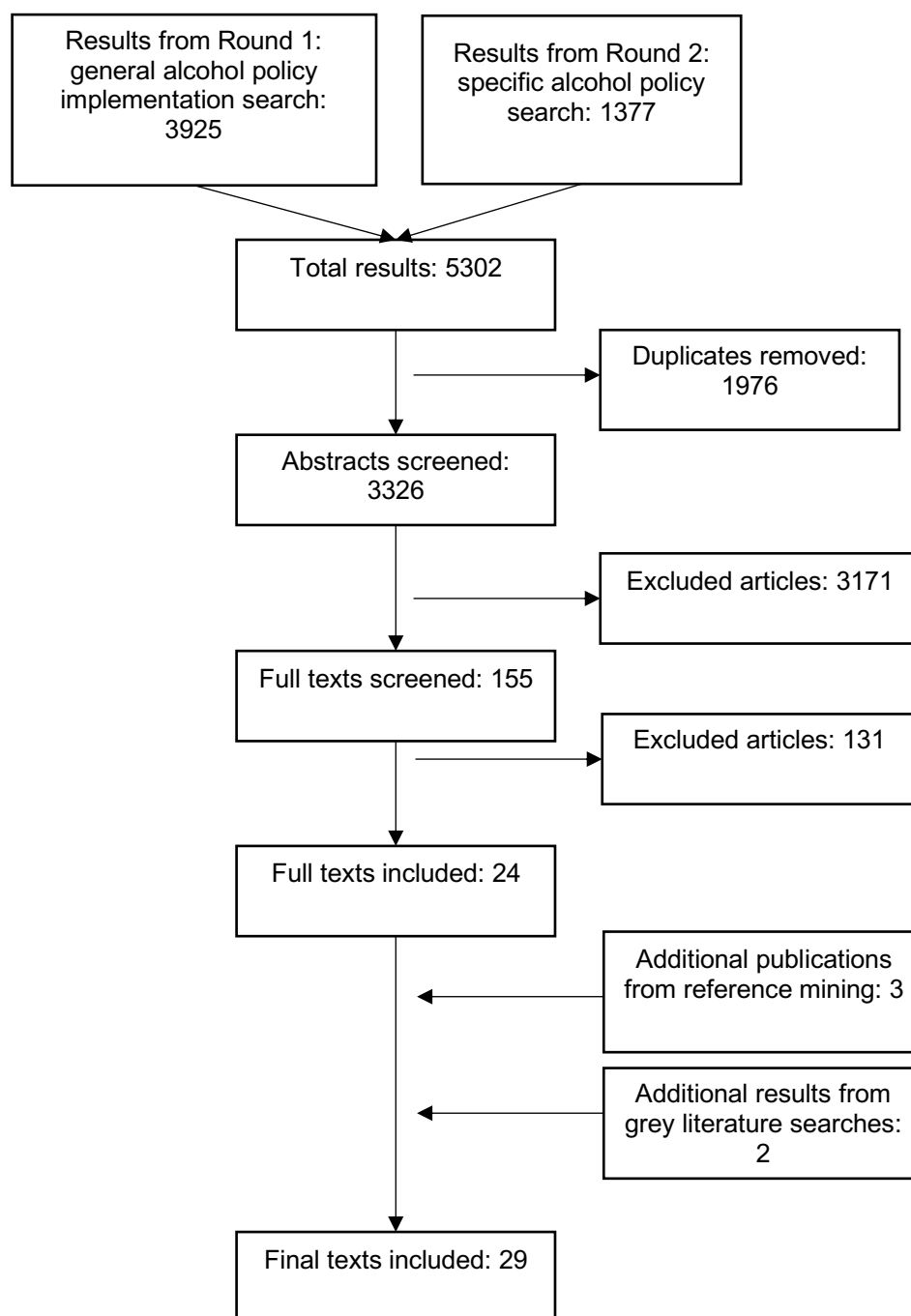


Table 3.2 List of Included Studies

	Author	Year	Title	Country Focus	Funder	Journal/Publisher	Quality Score
1	Berends et al	2016	Collaborative Governance in the Reform of Western Australia's Alcohol and Other Drug Sector	Australia	Not stated	Australian Journal of Public Administration	Intermediate
2	Casswell et al	2018	The Alcohol Environment Protocol: A new tool for alcohol policy	Scotland, New Zealand, St Kitts and Nevis, Thailand, South Africa, Vietnam	Multiple public funding sources within included countries	Drug and Alcohol Review	Intermediate
3	Chalmers et al	2016	Following the money: Mapping the sources and funding flows of alcohol and other drug treatment in Australia	Australia	Commonwealth Department of Health	Drug and Alcohol Review	Intermediate
4	Fitzgerald et al	2015	Large-scale implementation of alcohol brief interventions in new settings in Scotland: a qualitative interview study of a national programme	Scotland	Islington Borough Council	BMC Public Health	High
5	Fitzgerald et al	2017	Implementing a Public Health Objective for Alcohol Premises Licensing in Scotland: A Qualitative Study of Strategies, Values, and Perceptions of Evidence	Scotland	Lanarkshire Alcohol and Drug Partnership and NHS Health Scotland	International Journal of Environmental Research and Public Health	High
6	Fitzgerald et al	2018	Democracy and power in alcohol premises licensing: A qualitative interview study of the Scottish public health objective	Scotland	Lanarkshire Alcohol and Drug Partnership and NHS Health Scotland	Drug and Alcohol Review	High
7	Foster et al	2007	Implementation of the Licensing Act 2003: A national survey	England	Alcohol Education and Research Council, UK	Alcohol Education and Research Council, UK	Intermediate
8	Foster	2016	The Licensing Act (2003): its uses and abuses 10 years on	England and Wales	Institute for Alcohol Studies	Institute for Alcohol Studies	High
9	Grace et al	2016	Examining local processes when applying a cumulative impact policy to address harms of alcohol outlet density	England	NIHR	Health & Place	Intermediate
10	Hadfield et al	2015	The outsourcing of control: alcohol law enforcement, private-sector governance and the evening and night-time economy	England and Wales	Portman Group; Home Office	Urban studies	Intermediate
11	Hadfield et al	2009	'This town's a different town today': Policing and regulating the night-time economy	England and Wales	Alcohol and Education Research Council	Criminology & Criminal Justice	Low
12	Haggard et al	2014	Implementation of a multicomponent Responsible Beverage Service programme in Sweden - a qualitative study of promoting and hindering factors	Sweden	Not stated	Nordic Studies on Alcohol and Drugs	High
13	Hawkins et al	2014	'Water dripping on stone'? Industry lobbying and UK alcohol policy	United Kingdom	Alcohol Education and Research Council, UK	Policy and Politics	Intermediate
14	Herring et al	2008	Local responses to the Alcohol Licensing Act 2003: The case of Greater London	England	Middlesex University	Drugs: Education, Prevention & Policy	Intermediate

15	Humphreys et al	2010	Evaluating a natural experiment in alcohol policy: The Licensing Act (2003) and the requirement for attention to implementation	England	Not stated	Criminology & Public Policy	Intermediate
16	Lloyd et al	2014	Soft methods, hard targets: regional alcohol managers as a policy network	England	Policy Research Programme in the Department of Health	Journal of Substance Use	Intermediate
17	MacGregor et al	2013	An evaluation of the implementation of, and compliance with, the objectives of the Licensing (Scotland) Act 2005. Final Report	Scotland	NHS Health Scotland	NHS Health Scotland	High
18	Martineau et al	2014	Responsibility without legal authority? Tackling alcohol-related health harms through licensing and planning policy in local government	England and Wales	NIHR	Journal of Public Health	Intermediate
19	Mooney et al	2017	Investigating local policy drivers for alcohol harm prevention: a comparative case study of two local authorities in England	England	NIHR School for Public Health Research	BMC Public Health	High
20	Muhunthan et al	2017	Judicial intervention in alcohol regulation: an empirical legal analysis	Australia	Not stated	Australian and New Zealand Journal of Public Health	Intermediate
21	Parkes et al	2011	An evaluation to assess the implementation of NHS delivered Alcohol Brief Interventions: Final Report	Scotland	NHS Health Scotland	NHS Health Scotland	High
22	Randerson et al	2018	Changes in New Zealand's alcohol environment following implementation of the Sale and Supply of Alcohol Act (2012)	New Zealand	Health Research Council of New Zealand	New Zealand Medical Journal	Intermediate
23	Rieckmann et al	2009	Implementation of evidence-based practices for treatment of alcohol and drug disorders: The role of the state authority	United States	Robert Wood Johnson Foundation	The Journal of Behavioral Health Services & Research	High
24	Rod et al	2016	A case of standardization? Implementing health promotion guidelines in Denmark	Denmark	Danish Cancer Society	Health Promotion International	Intermediate
25	Thom et al	2013a	Partnerships: survey respondents' perceptions of inter-professional collaboration to address alcohol-related harms in England	England	Alcohol Research UK	Critical Public Health	Intermediate
26	Thom et al	2013b	The alcohol improvement programme: Evaluation of an initiative to address alcohol-related health harm in England	England	Policy Research Programme in the Department of Health	Alcohol and Alcoholism	Intermediate
27	Thompson et al	2017	Minimum alcohol pricing policies in practice: A critical examination of implementation in Canada	Canada	Not stated	Journal of Public Health Policy	High
28	Toner et al	2014	Perceptions on the role of evidence: an English alcohol policy case study	England	Policy Research Programme in the Department of Health	Evidence & Policy	Intermediate
29	Zahnow et al	2018	Lessons from Queensland's last-drinks legislation: The use of extended trading permits	Australia	ARC Linkage grant, Queensland Government, and others	Drug and Alcohol Review	High

Included publications came from a limited number of high-income countries, with the majority focusing on the UK context (19/29, 65%), particularly England (Figure 3.2). Publications labelled 'multiple' focused on a number of countries (e.g. Casswell et al., [2018] focused on Scotland, New Zealand, St Kitts and Nevis, Thailand, South Africa, and Vietnam). Additionally, despite no date restrictions on the search strings, most included publications were published in or after 2013 (Figure 3.3).

Figure 3.2 Included Publications by Country

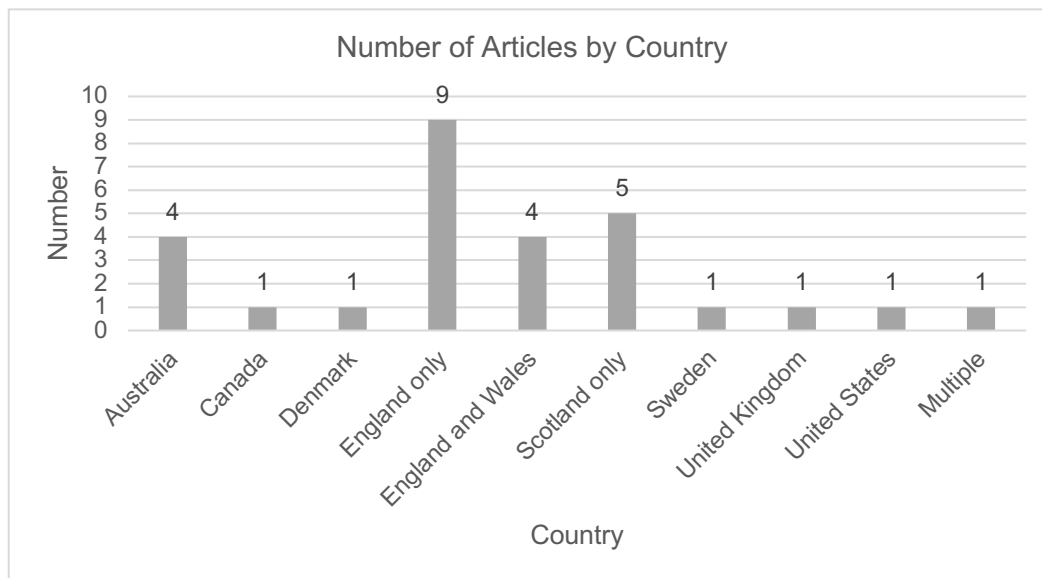
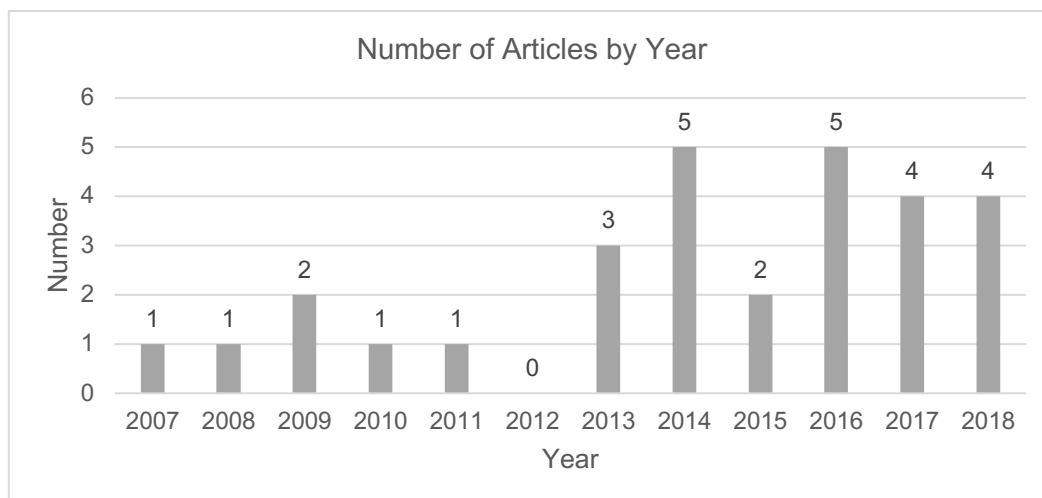


Figure 3.3 Included Publications by Year



Funding sources for the included publications varied. Of those articles that reported their funding source(s), most were from public sources (e.g. government or charities). However, as noted earlier, one article, by Hadfield and Measham (2015), reported a mix of public and private funding. Six studies did not report the source of funding for their research.

Table 3.3 below highlights the aim, methods, and key findings of each included article. Methodologically, the majority of primary studies reported in the articles (n=19) took a qualitative approach to analysing alcohol policy implementation. These primarily included semi-structured interviews and document analysis. This is unsurprising given the focus of this review, which specifically sought empirical research surrounding processes and experiences of alcohol policy implementation. It has been recognised that 'how'-type research questions lend themselves more readily to qualitative rather than quantitative approaches (Agee, 2009; Braun and Clarke, 2013). Nonetheless, four publications reported using quantitative methods (Foster et al., 2007; Humphreys and Eisner, 2010; Thompson et al., 2017; Zahnnow et al., 2018); five used mixed methods (Casswell et al., 2018; Parkes et al., 2011; Randerson et al., 2018; Rieckmann et al., 2009a; Thom et al., 2013b); and one publication used legal analyses of case law (Muhunthan et al., 2017).

A minority of studies (n=6) reported using a theoretical framework to inform or structure their study. Those that did refer to a theoretical framework drew from a range of areas of social science, including sociology, public policy, and implementation science. Additional articles drew from ideas concerning, for example, good governance and accountability (Chalmers et al., 2016); partnership working (Thom et al., 2013a); and evidence use in policy (Fitzgerald et al., 2017; Toner et al., 2014).

The alcohol policy topic discussed most often was licensing (e.g. discussion of the England/Wales *Licensing Act 2003* or Scotland's *Licensing (Scotland) Act 2005*). Of 29 studies included, 10 specifically discussed some aspect of the England/Wales *Licensing Act 2003* and five discussed the *Licensing (Scotland) Act 2005*. Another policy studied by multiple included publications was the UK Department of Health's Alcohol Improvement Programme, which was a time-limited, multi-component policy programme implemented between 2008-2011 (Toner et al., 2014). The Programme

aimed to reduce the rate of alcohol-related hospital admissions, and created Regional Alcohol Manager posts in each region to support implementation (Lloyd et al., 2014; Thom et al., 2013b; Toner et al., 2014).

Table 3.3 Aim, Methods, and Key Findings of Included Studies

	Author	Aim	Methods	Key Findings
1	Berends et al (2016)	Examine collaborative governance in alcohol sector reform, and assess extent to which collaborative governance process has been applied in this reform process.	Qualitative case study approach. Document review and group interviews; applied Emerson et al (2012) integrative framework on collaborative governance.	In context of increased service funding and a partnership approach, drivers for collaboration involve leadership and financial incentives for policy implementation. Approach to alcohol and drug sector reform in Western Australia has engaged stakeholders from government and services in collaborative governance approach, fostering mutually supportive and constructive relationships. However, service user participation was lacking.
2	Casswell et al (2018)	Report data on the implementation and enforcement of alcohol policies regarding availability, marketing, and drink driving.	Mixed methods study, used Alcohol Environment Protocol, which collects data on legislative and regulatory aspects of alcohol policy. Specified time period: 2013-2015. Data collection included review of policy and legislation documents, literature searches, observational surveys, administrative and commercial data sets and key informant interviews	Countries showed different extents of adoption of policy approaches, including variation in restrictions on outlet density and location, trading hours, marketing and sponsorship. All countries had a minimum purchase age and drink driving legislation. Rankings of enforcement of regulations also varied between countries. In countries with fewer resources, alcohol policies are less effective because of consequent lack of implementation and enforcement.
3	Chalmers et al (2016)	Develop and analyse mapping of funding for alcohol and other drug treatment.	Qualitative study. Conducted literature review of treatment financing and 190 key informant interviews in governmental and civil society sectors. Validated flow diagrams of funding with stakeholders (who and how many not clear).	Funding sources for alcohol and other drug treatment are complex, however this diversity is both beneficial (for mitigating the risk of shortfalls) and disadvantageous (adds to administrative burden).
4	Fitzgerald et al (2015)	Explore experiences of implementation of ABIs in settings outside primary healthcare in Scotland's national programme.	Qualitative study. Telephone interviews with 14 purposely selected public health practitioners, in antenatal, A&E and wider settings, representing all 11 mainland Health Boards in Scotland. Interview data analysed inductively, using framework matrix and 'implementation science' lens.	Achieving large-scale, routine implementation of ABIs is challenging in settings outside primary care, despite significant national support, funding, and a delivery target.
5	Fitzgerald et al (2017)	Explore how public health practitioners engaged with the licensing system following establishment of public health objective in Scottish licensing.	Qualitative study. Conducted 13 semi-structured interviews with public health actors (including representatives from the NHS, ADPs, and national or third sector organisations). Used inductive framework approach for analysis.	Introduction of public health objective did not quickly transform the goals and decisions of local alcohol licensing officials; public health practitioners surprised public health evidence was not always valued or understood. It will take time to embed public health as a routine consideration in the licensing environment. Relationships between public health and licensing actors may be vital to making progress.
6	Fitzgerald et al (2018)	Explore the experiences of public health actors engaging with licensing, in terms of	Qualitative study. In-depth, semi-structured interviews with 13 public health actors who	Changes to Scottish licensing meant to enhance democratic engagement and promote public health have been insufficient to

		their perceptions of the distribution of power and constraints on their influence within licensing.	had recent and extensive experience of involvement in local licensing in 20 licensing jurisdictions; analysed using inductive framework approach. <i>(note: appears to be same data corpus as used in Fitzgerald et al 2017 above)</i>	change the system or empower stakeholders to fully achieve those goals. Challenges include disproportionate influence of certain individuals, intimidating practices within licensing system, and limited accountability or meaningful public involvement.
7	Foster et al (2007)	Obtain views on the implementation and impact of the Licensing Act 2003.	Quantitative study. Conducted structured survey (with some open questions) with either Chair of Licensing Committee or head of alcohol licensing team in English local authorities. Sampled all 356 local authorities, response rate of 63%. Publication reports main descriptive analyses. Open questions used to extract themes.	Inconsistent picture across UK regarding effects of licensing changes on alcohol-related harms. Cost and availability of resources will be crucial influence on future responses to policing implementation of Licensing Act 2003. In future, issues of management and enforcement will continue to be important.
8	Foster (2016)	Assess the impact of the Licensing Act 2003 on the wider public sector 10 years after its implementation.	Qualitative study. Conducted 36 interviews with licensing stakeholders, including police, licensing officers, licensing lawyers, trade associations, academics, civil servants, and others. Held three additional workshops with 35 licensing stakeholders. Identified key themes within stakeholder responses, which were discussed with expert advisors.	Appears to be significant mismatch between written detail of the Licensing Act 2003 and its practical application; many consider Act to have been interpreted to the advantage of licenced trade. Act has not had impact on levels of crime and disorder, overall alcohol consumption, or diversity of night-time economy.
9	Grace et al (2016)	Examine local licence decision-making in the context of implementing Cumulative Impact Policies (CIPs).	Qualitative study. Conducted institutional ethnography to consider Cumulative Impact Policies (CIPs) in England, which are policies local authorities can implement under Licensing Act 2003 to try to tackle alcohol-related harms stemming from alcohol outlet density (similarities here with Scotland's 'overprovision statements'). Conducted 24 interviews and observed 21 licensing meetings.	CIPs are example of multi-level governance in which national and local interests, legal powers, and alcohol licensing priorities interact. However, CIPs have been contested on multiple grounds in practice, and are fluid in their objectives and framings; different stakeholders interpret CIPs differently.
10	Hadfield et al (2015)	Provide insights into changes which are entrenching private governance of the night-time economy, and investigate legislative and Corporate Social Responsibility implementation as applied to public drinking spaces and the operation of licensed premises.	Data drawn from two qualitative studies. <i>Study 1</i> : conducted 32 interviews with 40 participants (licensing officers, police, licensed premises managers, Department of health, resident's association, and drinks manufacturer) and analysed policy documents. <i>Study 2</i> : conducted observation of alcohol retail industry across eight English regions to assess how Social Responsibility Standards were working in practice.	A vacuum in traditional law enforcement is being filled by the Corporate Social Responsibility Agenda, with alcohol industries promoting 'voluntary alternatives' to the statutory roles and enforcement powers of city authorities and police. This replacement of traditional enforcement with self-regulation unlikely to support goals of achieving more diversified and inclusive urban night-time environments.

11	Hadfield et al (2009)	Consider recent policing and regulatory responses to the night-time economy in England and Wales.	Qualitative study. Two city case study sites (large and medium size English cities), conducted 70 qualitative interviews with alcohol policy implementation stakeholders (e.g. central and local government, police, licensing departments, social services, health and treatment services, and drinks retailers), as well as a focus group with seven local residents in one of the case study sites.	Enforcement powers were used sparingly in police interactions with premises, with their main utility being as levers or incentives for change which encouraged compliance with regulations. However, implementation of these powers varied across places and social contexts (despite central government attempting to standardise their use), as they are reinterpreted by local criminal justice practitioners and administrative bodies who are dealing with issues of resources, capacity building, and skills development
12	Haggard et al (2014)	Identify factors that promote or hinder the implementation of a multicomponent Responsible Beverage Service Programme in Swedish municipalities.	Qualitative study. Conducted 40 semi-structured interviews in six purposely selected municipalities. Undertook content analysis.	Local adaptation of the Programme may have resulted in less progress towards intended outcomes than expected. For successful implementation, argue potential users need to have positive sense of Programme, with core Programme components seen as logical and aligned with previous work and organisational structure. Evaluation and sufficient information about Programme also required.
13	Hawkins et al (2014)	Investigate means by which alcohol industry actors gain access to policymakers and strategies used to influence policy.	Qualitative study. Conducted 35 semi-structured interviews with a cross-section of alcohol policy stakeholders (elected parliamentarians, civil servants, public health advocates, and UK industry representatives). Interviews analysed thematically. Also undertook documentary analysis.	Strategies of alcohol industry actors focused on long-term relationship building with policymakers, involving provision and interpretation of information and promotion of self-regulation (e.g. through partnerships with government).
14	Herring et al (2008)	Study the local implementation of the Licensing Act 2003.	Qualitative study. Analysed licensing policies of 33 London Boroughs and undertook 11 in-depth interviews in five Boroughs (with licensing officers and chairs of licensing committees).	There is local diversity in the nature of licensing and in engagement of Councils in licensing across Boroughs. New partnerships working in licensing are emerging. Problems are observed in gathering adequate / appropriate data to monitor alcohol-related harm at local level; this evidence is needed to inform decision-making process.
15	Humphreys et al (2010)	Examine effects of change in licensing policy on practice of liquor retailing, and investigates application of natural experiment in crime prevention policy.	Quantitative study. Utilised licensing data (opening and closing times) from sample of 611 on-license premises. Data collected from before and after Licensing Act 2003 implementation. Analysed whether Act succeeded in cultivating staggered closing times.	Licensed premises differed in extent they adopted retailing changes under Licensing Act 2003's new regulatory framework. Suggest understanding and monitoring variation in policy implementation is a prerequisite to evaluating outcomes.
16	Lloyd et al (2014)	Explore how Regional Alcohol Manager (RAM) role developed (in context of implementing the Alcohol Improvement Programme), and explain the structure, role and impact of RAMs within conceptual frameworks of policy networks and government at a distance.	Qualitative study. Conducted unstructured interviews with all RAMs, semi-structured interviews with additional 31 national, regional and local policy contacts, and in-depth interviews with six national-level policymakers. Thematic analysis used deductively- and inductively-identified themes.	Government created new network of RAMs, who were expected to support progress on reducing alcohol-related hospital admissions. RAMs expected to impact local decision-making through partnership and persuasion. Observed clear division between those tasked with the central policy brief to deliver on a new policy and those who had to juggle central policy directives with local priorities; this resulted in tensions concerning work programmes RAMs developed.

17	MacGregor et al (2013)	Analyse the implementation of the Licensing (Scotland) Act 2005. Study objectives included: understand whether and how Licensing Boards address the five licensing objectives (including the public health objective); and understand how Licensing Boards interpret and enact key requirements of the Licensing Act 2005.	Qualitative study. Study conducted in three phases: (i) scoping documentary review (e.g. of licensing board policy statements and coping interviews (with trade and policy representatives); (ii) semi-structured telephone interview surveys with 30 Licensing Standards Officers and 20 Licensing Board members; and (iii) case study using focus groups and interviews with Licensing Board and Local Licensing Forum members. Interviewees did not include public health or police representatives.	Licensing (Scotland) Act 2005 has had positive impact on Scottish licensing system. Challenges implementing public health objective persist. In response to Act's implementation challenges, need for more, and better, guidance for Licensing Boards.
18	Martineau et al (2014)	Analyse implications for local alcohol control of changes to alcohol licensing laws and practice in England and Wales.	Qualitative study. Documentary analysis of current legislation governing local alcohol control in England and Wales. Documents collected through literature searching, hand-searching websites, and contacting key experts within and outside government.	England/Wales do not have statutory health licensing objective; public health stakeholders need to find ways to highlight considerable burden of alcohol harms in licensing processes. Health concerns can be addressed within current alcohol control framework by utilising potential for cross-sector collaboration within local government.
19	Mooney et al (2017)	Identify major characteristics and drivers of differences in patterns of local alcohol policies.	Qualitative study. Undertook case study in two contrasting Local Authorities in England, using semi-structured interviews with 13 key informants (from public health, licensing, and trading standards) and documentary analysis (of harm reduction strategies and statements of licensing policy). Carried out two-stage thematic analysis, resulting in seven inductive themes.	New powers over alcohol policy for English Local Authorities can produce different policies; differences are rooted in economic, opportunistic and personnel factors particular to each Local Authority. These differences in local circumstances can lead to varied prioritisation of alcohol-related harm prevention across Local Authorities.
20	Muhunthan et al (2017)	Examine role of court judgements on efforts in Australia to regulate harmful use of alcohol.	Legal analysis of case law. Analysed Australian case law (2010-June 2015) involving judicial review of administrative decisions relating to development applications or liquor licences for retail outlets, hotels and other on-licence premises. Forty-four cases identified using case law database, data extracted using systematic review techniques.	Majority of appeals were by industry against government decisions to reject a licence application. Public health research evidence had limited / no influence on cases, as there is no requirement in legislation to consider public health. Poor weighting of public health evidence resulted in high rates of industry success in these appeals.
21	Parkes et al (2011)	Assess implementation of NHS-delivered ABIs in Scotland.	Mixed-methods study. Used NHS Board progress reports and supplementary data. Additionally, undertook 26 semi-structured interviews with 17 key informants at national levels, and 13 interviews with health board strategic leads (representing 13 of 14 health boards). Identified three health boards as 'case studies', using board-level monitoring data and interviews.	Reach and impact of ABIs in Scotland was varied across Health Board areas. Variation in implementation may have resulted from, for example, different Health Board payment structures which result in primary care practices emphasising different aspects of ABI delivery. Developing more universal systems and standards for recording ABIs also important if ABIs to be effectively mainstreamed.

22	Randerson et al (2018)	Assess the impact (including enforcement) of the Sale and Supply of Alcohol Act 2012 (SSAA) in New Zealand on the alcohol environment from 2013-2015.	Mixed-methods. Employed the Alcohol Environment Protocol, with aim to document policy, enforcement, and compliance. Conducted 36 key informant interviews with police, liquor licensing inspectors, and public health officers (26 of whom were interviewed before and after Act implementation). Additional five interviews conducted with drink-drive enforcement officers. Interviewees asked to provide rankings and qualitative comments on aspects of alcohol environment. Analysis used ordinal logistic regression and thematic analysis.	SSAA led to slight reduction in alcohol availability during late night in urban centres. Development of Local Alcohol Policies deterred or delayed by appeals from alcohol industry. Slight increase in difficulty to obtain a premises licence, reportedly due to increased public opposition. However, need more support for public wishing to participate in licensing process, and more pragmatic approach to District Licensing Committees' consideration of evidence.
23	Rieckmann et al (2009)	Present findings from study of state substance abuse authority activities used to promote evidence-based practices for substance abuse treatment.	Mixed-methods. Used structured telephone interviews with 49 representatives of state substance use authorities to obtain quantitative and qualitative data about efforts to facilitate evidence-based practice adoption in US states.	Each state had unique approach to service delivery and funding for treatment services. Of four strategies used to adopt evidence-based practices, the highest emphasis was on infrastructure and development. Problems with options for financial support and accreditation could help to explain variation in actual adoption of evidence-based practices.
24	Rod and Hoybye (2016)	Examine process of implementation of Danish health promotion guidelines.	Qualitative study. Undertook ethnographic study using qualitative interviews and participant observation in four local governments. Focused on the work of health promotion officers. Analysis identified four emergent themes.	In absence of legislation regarding health promotion, guidelines served to regulate activities of local governments in subtle manner. Health promotion guidelines represented pragmatic approach to evidence by national authority, who used 'best available knowledge'. While guidelines critiqued for being vague, evidence of widespread attitude that recommendations were taken as evidence-based and therefore somewhat 'beyond discussion'. Evidence of local actors facing challenges in interpreting wording of recommendations and how they fit with actors' existing departments.
25	Thom, Herring et al (2013a)	Chart emergence of new forms of partnership working as pragmatic response to implementing alcohol policy at local levels, in context of UK Government's Alcohol Strategy (enacted in 2012). Examine assumptions underpinning efforts to promote partnership work and associated ongoing challenges.	Qualitative study. Employed open-discussion interviews with key informants (n=17) at national or regional level, and semi-structured interviews with 90 professionals with roles in local alcohol partnerships. Interviewed a further 20 people in two case study areas, using open-ended interview schedules. While study was strengthened by its discussion of theoretical partnership literature, a description of the data analysis was largely missing from its methods reporting.	Partnership working has proliferated in recent years; often constituted of combination of health and criminal justice. Further development of partnership model for policy implementation needs consideration of incompatibility between institutional and professional cultures. Need clearer analysis of which aspects of partnership working provide 'added value'. Contextual and process factors perceived as important to setting up partnerships.

26	Thom, MacGregor, et al (2013b)	Assess the Alcohol Improvement Programme (AIP), including its impact, the process of implementation, and which elements might serve as a 'legacy' in future.	Mixed methods. Employed interviews with: six national level policymakers; 25 regional level informants (e.g. Regional Alcohol Managers). Analysis used thematic content analysis. Also conducted structured telephone interviews with 44 Primary Care Trust alcohol leads and examined trend data for alcohol-related hospital admissions. Quantitative analysis utilised descriptive statistics. Four case studies conducted aimed at understanding the complexity and dynamics of implementing AIP.	No evidence the AIP had intended impact on alcohol-related hospital admissions. AIP was successfully delivered, and increased priority given to alcohol-related harm on local policy agendas. Factors influencing impact of AIP included nature of local context, extent of good partnership, availability of resources, and existence of focused objectives.
27	Thompson et al (2017)	Describe degree to which minimum alcohol prices in Canada are effective public health policy, and document approaches used for setting minimum prices across Canada's 13 jurisdictions.	Quantitative study. Collected data on minimum prices of alcohol for February 2014, from each jurisdiction's governing liquor control authority, and acquired on-premise prices from regulatory documents found online. Off-premise prices collected from liquor authorities.	Decisions on minimum price levels are made on financial/economic rather than public health grounds. Legislating regular inflation-adjusted minimum prices would protect value of alcohol products falling over time.
28	Toner et al (2014)	Explore competing influences which inform public health policy, using Alcohol Improvement Programme in England as case study. Sought to examine the ways research evidence informed decisions about High Impact Changes within England's Alcohol Improvement Programme. Study results	Qualitative study. Conducted structured telephone interviews with 44 Primary Care Trust alcohol leads. Conducted interviews with 20 local policy contacts (including Directors of Public Health) in four case study areas. Undertook 25 semi-structured interviews with regional level informants, including all Regional Alcohol Managers. At national level, all 10 members of Department of Health Alcohol Policy and Alcohol National Support Teams interviewed. Thematic analysis employed. Additional analysis of relevant documents (which documents, and how they were analysed, was not reported). (note: appears to be overlap of data corpus as used in Thom, MacGregor et al [2013] above)	Perception of High Impact Changes in England's Alcohol Improvement Programme as being evidence-informed allowed local implementers to support and legitimise their spending decisions about these Changes.
29	Zahnow et al (2018)	Explore patterns of extended trading permit use across Queensland, Australia, pre-and post-July 2016 following legislation change (<i>Tackling Alcohol-fuelled Violence Amendment Act 2016</i>) to reduce ordinary liquor trading hours.	Quantitative study. Utilised 24 months of licensing data to observe whether legislation had been under-inclusive and if licensees were utilising loophole of extended trading permits to keep licensing hours as usual. Used descriptive statistics and, difference-in-differences modelling approach, and Poisson regression models.	Article demonstrates under-inclusive nature of amendment led to licensed venues using extended trading permits to subvert intentions of legislation. Authors argue legislative loopholes are difficult to anticipate, therefore legislative evolution is required to 'patch' them after they are observed to arise. Tension also observed between responsibility for community safety given to community board, which is constituted by same venue owners as who are subverting the legislation.

3.3.2 Factors Influencing Alcohol Policy Implementation

Context and Variation in Implementation

The included literature suggested that alcohol policy implementation is influenced by context, and is often characterised by variation across local sites (e.g. Fitzgerald et al., 2018; Hadfield et al., 2009b; Humphreys and Eisner, 2010; Mooney et al., 2017; Parkes et al., 2011). The included studies suggested this variation was at least partially explained by the way local alcohol policy implementers undertake 'translation' work to implement a centrally-developed policy or strategy in their own contexts (e.g. Mooney et al., 2017) or by the governance of local implementation (e.g. Lloyd et al., 2014).

Examples of variation were most often observed in studies from the UK, but were reported across a range of alcohol policy topics. A clear example was in relation to delivery of ABIs across Scottish local areas, where a key finding from Parkes and colleagues (2011) was that "the extent of reach and impact of the ABI initiative was mixed across Scotland" (p. iii). The authors further reported that some Health Boards had tried to address these gaps, but that participants noted the need for a pragmatic approach to improving ABI 'reach'. For example, Heath Board participants reported sometimes having to work opportunistically with primary care practices who expressed higher interest in the initiative (Parkes et al., 2011).

In relation to Scottish alcohol licensing, Fitzgerald and colleagues (2018) observed that while licensing objectives in Scotland are intended to bring consistency to the licensing system, LB members have discretion in decision-making, leading the system to remain characterised by variation within and between LBs. The authors reflect that "greater accountability may increase consistency to some degree" (p.613), and point to a changing legislative context which requires LBs to report on how they have had regard to the licensing objectives. However, the authors warned against using accountability alone as a mechanism to enforce the licensing objectives. Further studies by Fitzgerald and colleagues (2017) and MacGregor and colleagues (2013) have also identified substantive variation in how licensing stakeholders interpreted and enacted different aspects of their role.

Considerations related to variation also appeared linked to other aspects of the local governance context in which implementation occurred, including the relationship of implementers to central government (Haggard et al., 2010; Herring et al., 2008; Lloyd et al., 2014). For example, Haggard and colleagues (2010) examined the implementation of a Responsible Beverage Service programme in Sweden. In their study, some participants reported the top-down approach of central government was problematic because it did not permit municipalities to contextualise the programme to their needs, meaning smaller municipalities ended up with programme priorities (e.g. reducing violence) that were better suited to large municipalities.

Studies of the Alcohol Improvement Programme within the UK provided a more detailed exploration of central-local relationships and local contextualisation. For example, Lloyd and colleagues (2014) were critical of the Department of Health's 'hands off' approach to their relationship with Regional Alcohol Managers, reporting the consequence that there was "considerable variability in the staffing and working environments associated with the role"(pp. 321). In other studies about the same Programme, the perceived levels of success of Regional Alcohol Managers varied (Thom et al., 2013b; Toner et al., 2014), with one study finding that initiatives within the Programme were adopted and developed variably across local areas, in ways to fit the local context (Thom et al., 2013b). However, the authors noted this arose from how "the ethos underpinning the [Programme] was to allow local areas flexibility in implementing change" (p.589). Finally, variation in alcohol policy implementation was also observed in relation to other aspects of the local governance context such as local areas' capacity and motivation to engage in effective partnership working and inclusive public involvement (Foster, 2016; Thom et al., 2013a). For example, in a study of how the *Licensing Act (Scotland) 2005* has been implemented, variation was observed in levels of public involvement in Scottish alcohol licensing (MacGregor et al., 2013).

Overall, the review results suggested that study authors sometimes appeared to find variation in implementation worrisome, in that it meant in certain sites policy went 'unimplemented' or there were gaps in coverage (Fitzgerald et al., 2018; Parkes et al., 2011). However, included studies also seemed to frame this local flexibility as being important for the purposes of contextualising the policy (e.g. Fitzgerald et al.,

2018²⁹; Thom et al., 2013b). This suggests that balancing the needs of local contextualisation against implementation consistency can be challenging and may be a useful dimension to explore in alcohol policy implementation research.

Factors Influencing Implementation

Many of the included publications identified more specific factors which were reported to influence implementation. These included: performance measurement for assessing, monitoring, or enforcing alcohol policy implementation (including use of targets); partnership or other collaborative working; availability of sufficient resources (monetary or otherwise); public involvement in decision-making; and availability of high quality, relevant evidence to inform decisions. Table 3.4 below shows which included publications consider each of these factors, and provides a reader with an overview of how often each topic arose in the included literature (including, strikingly, how often publications discussed multiple topics). The subsections below then discuss each factor in order of how frequently they arose in the literature, considering the ways each influences (i.e. may facilitate and/or challenge) implementation. Given that I quality assessed all but one publication to be 'high' or 'intermediate' quality (see Table 3.2), I will not comment on the quality of publications below, except where a particular point rests only on the one study I assessed as being of 'low' quality (Hadfield et al., 2009b).

²⁹ Note Fitzgerald and colleagues (2018) reported both views

Table 3.4 Factors Discussed in Included Publications

	Publication	Resources	Evidence Use	Performance measurement	Partnership or collaborative working	Public involvement
1	Berends et al (2016)	X			X	
2	Casswell et al (2018)	X		X		
3	Chalmers et al (2016)	X		X		
4	Fitzgerald et al (2015)	X	X	X		
5	Fitzgerald et al (2017)		X		X	X
6	Fitzgerald et al (2018)	X		X	X	X
7	Foster et al (2007)		X	X	X	X
8	Foster (2016)	X	X	X	X	X
9	Grace et al (2016)	X	X		X	X
10	Hadfield et al (2015)			X		X
11	Hadfield et al (2009)		X	X	X	X
12	Haggard et al (2014)	X	X			
13	Hawkins et al (2014)	X	X		X	
14	Herring et al (2008)	X	X	X		X
15	Humphreys et al (2010)			X		
16	Lloyd et al (2014)	X	X	X	X	
17	MacGregor et al (2013)	X	X	X		X
18	Martineau et al (2014)		X		X	
19	Mooney et al (2017)	X	X			
20	Muhunthan et al (2017)	X	X			
21	Parkes et al (2011)	X		X	X	
22	Randerson et al (2018)	X	X	X		X
23	Rieckmann et al (2009)	X	X			
24	Rod et al (2016)	X	X	X	X	
25	Thom et al (2013a)	X			X	
26	Thom et al (2013b)	X	X	X	X	
27	Thompson et al (2017)		X			
28	Toner et al (2014)		X	X		
29	Zahnow et al (2018)					X
	Total	20	20	17	14	11

Resources

The availability and importance of different types of resources emerged as an important factor for alcohol policy implementation in 20 studies. These studies were consistent in reporting resources were necessary to enable alcohol policy implementation work (e.g. Casswell et al., 2018; Fitzgerald et al., 2015; Foster, 2016), and that capacity to undertake, or engage in alcohol policy was associated with greater resources (e.g. Haggard et al., 2010; Hawkins & Holden, 2014).

Studies most often identified a lack of resources (specifically inadequate or unsustainable funding) as being a challenge to alcohol policy implementation. For example, the issue of budget cuts or otherwise constrained resources was a consistent and direct barrier to implementation (e.g. Hadfield et al., 2009b; Herring

et al., 2008; Thom et al., 2013b). The included publications also suggested that imbalances in how resources were distributed between given policy initiatives or implementation stakeholders could also be problematic. For example, while ABIs were noted as being a relative 'success story' in Scotland, for having achieved key targets, Parkes and colleagues (2011) suggest that the prioritisation of the ABI programme may have absorbed energy and resources that were sorely needed for other, locally-identified alcohol-related issues.

Additionally, a relative lack of resources among policy implementers compared with other alcohol stakeholders was found to be challenging in certain circumstances. For example, it was evident that the alcohol industry's substantial resources allow them the capacity and flexibility to engage with alcohol policy, which clearly contrasts with the situation of local government actors experiencing budget reductions (Hawkins and Holden, 2014). At a local level, Grace and colleagues (2016) reported that the licensing process also appeared to "favour well-resourced stakeholders who had the time, knowledge and skills to present their own interests as commensurate with the requirements of [the local alcohol policy]" (p.82).

From an international perspective, Chalmers and colleagues (2016) were concerned with whether implementation arrangements constituted 'good governance', particularly in terms of what funding relationships could reveal about transparency and accountability within the treatment system. By mapping the funding flows for alcohol and drug treatment in an Australian context, the researchers found that services draw on multiple funding sources. While this helped protect services from funding shortfalls, it created challenges for service providers who consequently must navigate multiple (and sometimes competing) funding and accountability frameworks, ultimately hindering alcohol policy implementation work (Chalmers et al., 2016).

It was less common for studies to empirically identify funding as a positive contributor to alcohol policy implementation, possibly because the opportunity to observe this arose less frequently in resource-constrained contexts. Despite this, three studies were able to identify circumstances in which sufficient funding had been a positive contributor to implementation. Fitzgerald and colleagues (2015) and Parkes and colleagues (2013) both reported that the substantial influx of funding

provided to implement the ABI programme in Scotland was crucial for the programme's relatively successful implementation. In England, Thom and colleagues (2013b) found local areas which were 'early implementers' of the Alcohol Improvement Programme were provided sufficient resources to help them support key actions, including establishing service delivery infrastructure, supporting new relevant initiatives, and strengthening partnerships. However, these same authors made the point that the overall programme was given a relatively modest budget with respect to what it was intended to accomplish, and they highlight this as one of the key sources of failure (Thom et al., 2013b).

Beyond funding, a range of other resources were identified as necessary for successful alcohol policy implementation. These included organisational infrastructure to deliver services, and human resources such as senior staff buy-in, leadership, enthusiastic individuals and strong, communicative teams (Fitzgerald et al., 2015; Haggard et al., 2010; Parkes et al., 2011). Parkes and colleagues (2011) reported a number of non-monetary resources /sources of support which helped facilitate the implementation of Scotland's ABI programme. For example, they reported that national events which were organised to support local areas in achieving the ABI delivery targets were well received by their study respondents. The study also reported perceived benefits of having coordination resources, for example the support provided by the National ABI coordinator situated at the Scottish Government. Further, the authors observed that the organisational infrastructure (including adequate time and planning) and Scotland-wide training programme for ABI delivery was crucial for establishing the programme. However, the ABI Delivery Support Team was perceived by participants as being established too late in the planning process, and without sufficient connection to frontline delivery or with a well-defined remit (Parkes et al., 2011).

Lastly, the included publications suggested that resource considerations impacted the administration of local alcohol licensing systems. In particular, licensing committees feared having their decisions appealed because of the associated costs for the local Council (Fitzgerald et al., 2017; Foster, 2016; Herring et al., 2008). As a result, it was observed that local areas tended to develop local licensing policies that would not attract litigation or negative publicity. For example, this led many of the first local licensing policies in England to be similar and relatively weak (Herring et

al., 2008). A lack of resources also appeared to influence the capacity of the licensing system to implement relevant legislation. For example, Foster (2016) found that cuts to police services had negatively impacted on the capacity of police to engage in the administration and enforcement of licensing policy. Further, this study noted the lack of funding provided to administer the licensing system - the Act's licensing fee system did not sufficiently cover the cost of running the licensing system. Foster reported that this issue was compounded by local administrative policy which prevented the licensing system in England from being supported by general local government funds.

Evidence Use

A total of 20 included publications discussed evidence use in alcohol policy implementation; interest in this topic seemed to be linked to an assumption that better evidence use would improve alcohol policy implementation or outcomes. In discussing evidence use, studies made the link to implementation both directly and indirectly: Directly, in terms of evidence being used to inform decision-making during implementation, and, indirectly, in terms of framing evidence as generally being important to use and share in the context of local actors' implementation work. The depth to which studies examined evidence use varied. Some studies mentioned evidence quite briefly, and framed general issues about evidence use (such as a lack of evidence) as a challenge for implementation (e.g. MacGregor et al., 2013; Randerson et al., 2018; Rieckmann et al., 2009b). Others, however, explored evidence use in more detail, for example by examining different actors' perspectives on evidence or what evidence is considered relevant in health or non-health contexts (e.g. Fitzgerald et al., 2017; Martineau et al., 2013; Muhunthan et al., 2017; Toner et al., 2014).

Included publications suggested alcohol policy implementers (at both national and local levels) drew upon a range of evidence in their work. This included residents' views and testimonies, health statistics, information from licensees or local business, and police statistics and data (Fitzgerald et al., 2017; Foster et al., 2007; Grace et al., 2016; Lloyd et al., 2014; Toner et al., 2014). Uses of evidence were also represented in multiple ways. This included relatively straightforward, linear use to inform policy and practice decisions, such as using locally developed Needs Assessments to help justify chosen priorities (Mooney et al., 2017). This also

included more complex uses, such as the synthesis of empirical and socio-political contextual knowledge (Toner et al., 2014). Additionally, included publications suggested that evidence was sometimes used more ‘symbolically’ to support effective implementation – this included lending legitimacy or credibility to a particular programme, or to protect decisions from critique or appeal. For example, certain articles noted that being seen to be ‘evidence-based’ would lend credibility to a particular programme, helping to garner stakeholder buy-in (Fitzgerald et al., 2015; Haggard et al., 2010; Rod and Hoybye, 2016; Toner et al., 2014). As another example, Herring and colleagues (2008) reported UK local licensing decision-makers sometimes tried protect themselves against expensive appeals by ensuring there was a sound evidence base for their decisions.

Challenges with using evidence arose frequently within included studies, particularly in terms of generating or accessing relevant and quality evidence, or disagreement over what constituted relevant evidence. First, a perceived lack of (relevant) evidence to inform implementation was reported in seven studies (Fitzgerald et al., 2015; Foster, 2016; Hadfield et al., 2009b; Herring et al., 2008; Martineau et al., 2014; Randerson et al., 2018; Toner et al., 2014). This included concerns about the quality of the evidence implementers had available to them – for example whether they could rely on available police and hospital statistics (Herring et al., 2008) – and whether evidence was appropriate for the setting in which it was needed. For example, Fitzgerald and colleagues (2015) reported evidence about ABI effectiveness was required for settings beyond primary care. Toner et al. (2014) observed that certain implementing organisations (in this case, Primary Care Trusts in England) responded to this challenge by undertaking their own local context-specific research.

Second, the included studies suggested there were contested perceptions of what is persuasive and appropriate evidence within alcohol policy implementation processes. For example, Toner and colleagues (2014) observed tensions between ‘scientific’ and ‘experiential’ evidence in local alcohol policy decision-making, as well as varied perspectives on what evidence was considered convincing, or persuasive. To illustrate, the authors reported mixed perspectives among participants over the appropriateness and adequacy of available research evidence for local decision-making (Toner et al., 2014).

Further, in the Scottish alcohol licensing context Fitzgerald and colleagues (2017) found that public health practitioners and licensing stakeholders had different values and beliefs about evidence. They reported that public health actors perceived licensing actors did not always value or understand the public health evidence provided. In their study, public health interviewees emphasised that the implementation of a public health objective in Scotland required all actors to accept the 'whole population approach' to alcohol policy. However, they perceived not all relevant actors had adopted this perspective, despite the public health evidence available to support it. As an example, interviewees reported that, despite being presented with evidence of alcohol-related harms, not all licensing stakeholders agreed that current Scottish alcohol consumption levels and related harms were significant problems. The authors ultimately point to the possibility of different "cultures of evidence" between public health and licensing actors (a point which Chapter 7 explicitly builds upon), though this conclusion is limited by the study's exclusive focus on the perspectives of public health actors.

Third, the included studies suggested that understandings of legal evidentiary requirements to link alcohol availability and harm are contested. From a public health perspective, a key problem in both Scotland and England/Wales was the requirement within licensing to present specific evidence that established a link between a given premises and the potential for alcohol-related harm (Foster, 2016). Grace and colleagues (2016) found different licensing stakeholders disagreed about the extent to which alcohol-related harms could, or needed to be, linked to a particular premise or area in order to be persuasive and credible. The results suggest there are differences between public health and licensing perspectives on evidence, but also potentially a diversity of perspectives within licensing that are worth exploring, particularly in terms of how these differences may impact implementation.

This confusion about legal requirements to link alcohol availability and harm was particularly evident in publications about the *Licensing Act 2003*, in which different authors came to different conclusions about how the legislation frames the need for evidence and what types of evidence are relevant (Foster, 2016; Martineau et al., 2014). To explain, in a review of the *Licensing Act 2003*, which incorporated legal

input from a licensing barrister, Foster (2016) argues that the Act does not actually require a vast amount of ‘factual evidence’ of the link between alcohol-related harms and a particular premise/area, or for decision-makers to take a ‘premises by premises’ approach. Instead, Foster states that the Court of Appeal has determined licensing decisions can involve an ‘evaluative judgement’ about a local area and potential harms. Foster further argues that a “rational but nuanced view of causality” is sufficient for informing licensing decisions, thus the evidential standard was not as high as often perceived (Foster, 2016, p. 178).

However, this analysis is somewhat in contrast with the analysis of the *Licensing Act 2003* by Martineau and colleagues (2014) who, in referencing the Act’s guidance from the Home Office, state that “licensing authorities can only consider health-related evidence that directly links the premises in question to a threat in one of the named licensing objectives” (p. 3). This suggests more restrictive evidence expectations than that perceived by Foster. Martineau and colleagues go on to argue that licensing committees need a combination of data and arguments that are in reference to either a specific local area or a particular applicant. By being more specific to an area or premises, evidence has more legal weight and is better able to protect a licensing committee from appeal. Where Foster (2016) assesses that licensing committees are relatively flexible to consider evidence they deem relevant, Martineau and colleagues (2014) emphasise that the lack of a public health objective in England means health-related data is irrelevant unless it can be linked to one of the existing licensing objectives. Overall, it appears from the literature that fundamental understandings of legal evidentiary requirements are contested under the *Licensing Act 2003*, with implications for evidence use during the legislation’s implementation.

While similar legal-type analyses were not available for the *Licensing etc. (Scotland) Act 2005*, the contested nature of evidence within licensing was also observed in the Scottish context, in which challenges were reported about implementing the *Licensing Act 2005*’s public health objective (discussed already in relation to Fitzgerald et al., 2017). MacGregor and colleagues (2013) have noted a key barrier to implementing Scotland’s public health objective was a lack of understanding among implementers about which evidentiary sources should be used during implementation. These authors also found that more consistent, robust, and

comparable data collection regarding the key provisions of *Licensing Act 2005* was needed in order to inform licensing decision-making (MacGregor et al., 2013).

From an international perspective, Muhunthan and colleagues (2017) used a method unique to the included literature when they examined court judgements regarding alcohol licenses in Australia. They reported that judicial discretion regarding what counted as persuasive evidence was an important factor in understanding why court decisions were most often in favour of industry. For example, within these courts, different types of evidence were given different 'weight', and industry-presented evidence was often weighted more heavily than public health evidence, partly because public health-related arguments were often discounted where population-level evidence could not be supported by locality-specific evidence (Muhunthan et al., 2017). The authors suggest this may have been because (i) the relevant legislation did not include a mandate to consider public health, or (ii) because of a narrow definition of 'causation' in the relationship between alcohol and health which meant public health evidence often could not meet the high 'evidentiary burden' (Muhunthan et al., 2017). This aligns with what was observed in the UK context, and lends empirical support to observed concerns within local government about having decisions appealed and the costs associated with this. Indeed, Muhunthan et al. (2017) found that local governments (as opposed to national governments) were the most frequent government stakeholders to have legal actions brought against them within the alcohol licensing system.

While there has been a strong focus in the included literature on evidence use in licensing, this has often been from public health actors' perspectives; empirical research with licensing decision-makers about their evidence use, to access their perceptions first-hand, is still needed. Further, the results suggest that there is a knowledge gap regarding evidence use by alcohol policy implementation stakeholders beyond their engagement in the licensing context. Particular gaps appear to be in understanding evidence use by non-health stakeholders involved in implementation (e.g. police, education, social care, etc.), and in evidence use within local alcohol policy partnerships.

Performance Measurement

Seventeen publications reported on different approaches being used to measure, monitor, and enforce progress in alcohol policy implementation. This typically included the use of key indicators or targets that implementers were expected to prioritise and achieve, such as alcohol-related hospital admissions (Lloyd et al., 2014). Four of the included studies described how targets could help facilitate implementation, such as by helping to prioritise alcohol policy locally, or giving a valuable focal point for planning related actions (Fitzgerald et al., 2015; Parkes et al., 2011; Thom et al., 2013b; Toner et al., 2014). One further study claimed a lack of agreed targets or outcomes led to the failing of a social responsibility policy (Hadfield and Measham, 2015), however this seemed to be grounded in an assumption that establishing a target could address the more general need for better enforcement of licensing regulations.

A relative success story within the included literature was the implementation of Scotland's ABI programme (Fitzgerald et al., 2015; Parkes et al., 2011). Included studies reported that, by identifying a target number of ABIs to be delivered across Scotland and establishing a practical and robust monitoring system, the Scottish Government helped to ensure this intervention was prioritised locally (Fitzgerald et al., 2015; Parkes et al., 2011). Notably, however, Fitzgerald and colleagues (2015) identified some unintended consequences of the target, such as staff feeling "coerced" (p.6) into delivering on it.

Included studies also reported concerns regarding targets, and broader issues related to performance measurement of implementation (e.g. monitoring and enforcement). Three included publications reported alcohol policy implementers were critical of the use of single indicators to measure entire programmes of work (Parkes et al., 2011; Thom et al., 2013b; Toner et al., 2014). In a study of the Alcohol Improvement Programme, Thom and colleagues (2013b) were critical of the programme being measured by a narrow indicator (alcohol-related hospital admissions) and argued that a broader range of alcohol-related harm measures would be more appropriate. Toner and colleagues (2014), examining the same Programme, similarly reported results indicating measures of the Programme were too narrow and "failed to embrace the broader range of alcohol-related harm" (pp. 106). These results are important from an implementation and accountability

perspective, because it appears participants in these studies felt the indicator (an accountability mechanism) was not a fair or appropriate measure of their implementation work. Further, Parkes and colleagues (2011) reported a concern among participants that a simple target becomes a 'numbers exercise' for implementers without meaningful embeddedness in practice. In terms of other unintended consequences, Parkes and colleagues (2011) noted the prioritisation of this target could overshadow the need to act on locally-identified issues, and Fitzgerald and colleagues (2015) identified the risk of "distortions in recording such that reported ABI figures were felt in some cases to be misleading" (p.6). Generally, it seemed the target became "important for implementation but creat[ed] perverse incentives to maximise reporting of ABI delivery" (Fitzgerald et al., 2015, p.6).

In four studies, performance measurement concerns arose around a perceived lack of clarity about who had responsibility for meeting targets (Fitzgerald et al., 2015; Parkes et al., 2011), and complications surrounding the reporting (i.e. accountability) arrangements (Lloyd et al., 2014; Thom et al., 2013a). These were reported as challenges for implementation, with Fitzgerald and colleagues (2015) reporting that, where lines of responsibility were unclear, "interviewees tended to report more of a struggle with the whole [implementation] process" (p. 6). For example, Lloyd and colleagues (2014) reported that Regional Alcohol Managers in England's Alcohol Improvement Programme were pulled in three directions: they reported to Health Board managers through line management arrangements; however also felt it necessary to prioritise locally identified needs in order to maintain their local relationships (and thus effectively support/influence local alcohol policy implementation). Finally, they were answerable to the Department of Health. The complexity of these obligations and responsibilities led the authors to conclude that this need to "juggle central policy directives with local priorities" (p. 325) was a challenge to Alcohol Managers' implementation work. Overall, these particular publications suggest that establishing clear lines of accountability is important for implementation but do not investigate this in great detail. The complexity that partnership working adds to these issues is discussed further in the partnership subsection below.

In terms of actually documenting performance or progress towards targets, challenges and key concerns in this area were often reported as being linked to

issues about attaining and organising data. For example, problems accessing data (especially hospital data) were perceived as important barriers to ongoing mapping of alcohol-related harm (Herring et al., 2008). In relation to the Alcohol Improvement Programme, Toner and colleagues (2014) reported participants' frustration with how alcohol-related hospital admissions were actually recorded and subsequently counted against this target. In this circumstance, admissions only partially attributable to alcohol were often included, and it appeared the non-standardised coding of these admissions across local areas or within hospitals led to 'wild fluctuations' in the numbers. A related issue of documenting progress for the purposes of fulfilling multiple funders' demands, as discussed by Chalmers and colleagues (2016) was discussed above in relation to resources.

Additionally, technical challenges were noted which prevented the use of information for monitoring and informing local implementation decision-making. For example, in Scotland it was found that local IT systems were sometimes not adequately linked to each other (Fitzgerald et al., 2015), or responsibility for developing appropriate IT systems had been devolved to Health Boards who struggled because of a lack of available resources and expertise (Parkes et al., 2011). This had implications for the additional barriers of ensuring data accuracy and the capacity to effectively share data within the context of implementation (e.g. to demonstrate implementation progress). The challenge of effectively sharing data arose in multiple articles as being both a priority (Thom et al., 2013a, 2013b) but also an infrastructure issue (Foster, 2016; Hadfield et al., 2009b).

Partnership or Collaborative Working

Fourteen publications discussed partnership working and collaboration, and consistently represented partnership as a supportive factor or facilitator of effective alcohol policy implementation.

All but two of the publications in this section were written regarding the UK context, where existing guidance around alcohol policy has strongly encouraged partnership working (Martineau et al., 2014; Thom et al., 2013a). For example, included publications noted the England/Wales *Licensing Act 2003* requires a partnership approach to implementation (e.g. Foster, 2016; Herring et al., 2008). Authors such as Thom et al. (2013a) have identified partnership working as a key factor which

influences how policies and programmes are implemented (although not necessarily that partnership working is key to success). In light of this, it was unsurprising to find the literature suggests there has been a proliferation of partnership working in UK alcohol policy, and a reported commitment among research participants to this approach (Thom et al., 2013a).

Alcohol policy implementation partnerships were reported as often being multi-sectoral in their membership, given the relevance of alcohol-related harm to a range of policy areas (Lloyd et al., 2014; Martineau et al., 2014). In their study focusing on alcohol partnerships in England/Wales, Thom et al. (2013a) observed these partnerships were most often comprised of criminal justice and health representatives, sometimes also including education, employment, and social services. This appeared to lead to a key challenge of partnership working, as situations could arise in which partners' own interests, professional cultures or experiences conflicted with those of other partners, or with the overall goals of the partnership itself (Martineau et al., 2014; Thom et al., 2013a).

Other challenges were also identified. For example, Thom and colleagues (2013a) reported pressures among local implementers to respond to local needs while maintaining commitments from senior officials and key institutions. This same study highlighted a further challenge, that "working with multiple organisations and partnerships within the same area...complicated lines of responsibility and accountability" (Thom et al., 2013a, pp. 67–68).

Another accountability-related challenge was illustrated by Lloyd and colleagues (2014), who examined the functions of Regional Alcohol Managers within the Alcohol Improvement Programme across nine English health regions. The authors observed that Managers were intended to work in partnership to help support, influence and coordinate alcohol policy initiatives, but they did not have the power to actually 'implement' action locally. Their 'soft' methods of persuasion were intended to help them contribute to the achievement of a 'hard' target of reducing alcohol-related hospital admissions, the key indicator by which the Alcohol Improvement Programme was measured. This meant Managers were being given responsibility for a target they did not have the power to take direct action on, a challenge because it "is impossible to carve out the particular impact of the soft influencing

skills of the [Managers] on the hard outcome of [alcohol-related hospital admissions]” (Lloyd et al., 2014, p. 326). These challenges suggest that further understanding about effectively organising the governance of local alcohol partnership working, in order to support policy implementation, is needed (especially in contexts, such as the UK, where partnership-based approaches are being strongly encouraged [Cook, 2015]).

Despite challenges to working collaboratively and in partnership, included studies reported that local alcohol policy implementers subscribed to positive notions of this approach (Martineau et al., 2014; Parkes et al., 2011; Thom et al., 2013a). Despite the relative lack of empirical data within the included publications demonstrating partnership working led to improved outcomes, studies appeared to suggest that actors maintained the assumption that partnership working was helpful. However, one publication did note that the idea of partnership often goes uncritically accepted (Thom et al., 2013a): “despite the widespread belief in partnership working – which crosses political and policy divides – there is no good evidence to suggest that partnerships work or to indicate which aspects of partnership approaches are providing added value” (Thom et al., 2013a, pp. 74–75). The authors ultimately advocate for more research into what ‘added value’ partnerships actually provide in alcohol policy implementation.

Only one example (Parkes et al., 2011) of where partnership working has been demonstrably successful in enabling local actors to implement alcohol policy was available in this review. Parkes and colleagues (2011) found that Health Boards’ collaborations with voluntary sector organisations helped to deliver ABIs to ‘hard to reach’ populations and ensure equitable delivery across different areas. One other study, this time of where more informal ‘collaboration’ between stakeholders had a positive impact, was in Grace and colleagues’ (2016) study in England. The authors found that collaboration between licence applicants and local alcohol policy stakeholders (e.g. police) could help ensure licence applications included “features considered aligned with [Cumulative Impact Policy³⁰] goals” (p. 81).

³⁰ A policy intended to help local authorities limit the unwanted growth of alcohol outlet density.

The results suggested partnership working was a central and consistent aspect of the local governance of alcohol policy implementation (and is likely to be for the foreseeable future in the UK). However, understanding how partnership working shapes alcohol policy implementation work remains under-studied and the work that does exist provides only limited support for this approach.

Public Involvement

Eleven publications discussed public involvement in alcohol policy implementation. Like partnership working, there seemed to be an assumption by authors and their study participants that public involvement is a positive contributor to the general work of alcohol policy implementation. The relevant publications most commonly (in seven studies) discussed public involvement in relation to local licensing in the UK (Fitzgerald et al., 2018; 2017; Foster, 2016; Foster et al., 2007; Grace et al., 2016; Herring et al., 2008; MacGregor et al., 2013). In England/Wales this was in the context of legislative changes made by the *Licensing Act 2003*, in which it was perceived the Act would give residents a 'stronger voice' and the ability to engage more easily (Herring et al., 2008). In Scotland this was in relation to enacting the public health objective under the *Licensing Act 2005* (Fitzgerald et al., 2017, 2018). There was limited discussion of public involvement in alcohol policy implementation in the UK beyond licensing (exceptions being two night-time economy-focused studies by Hadfield and colleagues (2009b, 2015)).

Most of the studies reported that public involvement may be occurring (if somewhat variably across areas), often reporting that interviewees perceived public involvement 'might' or 'could be' a powerful influence on implementation decisions (e.g. Fitzgerald et al., 2017). Fitzgerald and colleagues (2018) explicitly recognised that the link between public involvement and implementation was based more on reasoning, noting that while public consultation in Scottish licensing was perceived as an important component of the implementation process by their interviewees, the authors were not able to presume what the outcomes of more public consultation would be. Thus, some uncertainty remains about whether greater public involvement in alcohol policy implementation would indeed 'improve' implementation processes (and, consequently, improve public health outcomes). Indeed, only two studies reported empirical evidence that it had had an actual positive influence on implementation decision-making: In New Zealand, increased public opposition to

new licensed premises was found to have helped to make it harder to obtain a new licence (Randerson et al., 2018); and in England, Foster (2016) reported some participants felt public involvement had been useful for adding “legitimacy and weight” (p.115) to local implementation actions.

Included publications more readily identified challenges to public involvement than examples of where it was working well. Challenges included licensing systems which were relatively intimidating, inaccessible or opaque, and local authorities which did not actively encourage public participation, or even discouraged it (e.g. through poor communication about licence applications) (Foster, 2016; Hadfield et al., 2009b; MacGregor et al., 2013). For example, Foster’s (2016) evaluation of the *Licensing Act 2003* suggested that the Act had not actually greatly improved the accessibility and transparency of licensing compared with the previous system (Foster, 2016). Overall, the study suggested that while the Act may have attempted to create more opportunity for residents to be involved in licensing, most local authorities did not actively encourage this participation, and the author recommended better public engagement in licensing be pursued (Foster, 2016).

Three studies highlighted further issues which arose once the public was involved in alcohol policy implementation broadly. Procedurally, in terms of barriers to public involvement, residents reported not being clearly told what evidence they could present to licensing decision-makers which would be persuasive (Herring et al., 2008). However, from a licensing stakeholder perspective, one study provided a critique that residents sometimes had “unrealistic demands, [and] did not always appreciate that an agreed process had to be followed” (MacGregor et al., 2013, p.37). In terms of the impact of public involvement, Hadfield et al. (2009b) reported that the public’s concerns may not be adequately taken into account by statutory stakeholders such as the police (although note this publication scored low in my qualitative appraisal, see Table 3.2). These results highlight potential persistent challenges for ensuring the public can effectively participate in licensing, which is a key aspect of Scotland’s alcohol strategy (see Chapter 2). This may be an important issue for the Scottish context in which there have been calls to support communities to participate in licensing (Alcohol Focus Scotland, 2017e) and efforts to support community empowerment more broadly (e.g. Scottish Government, 2017c).

Overall, the included publications suggested that while public involvement was often assumed by authors to be another positive contributor to alcohol policy implementation, the ability or efforts of different local areas to facilitate public involvement varied, with many challenges being identified. There appears to be a gap in knowledge about public involvement beyond the licensing context of the UK or in partnership working contexts. Finally, the included publications did not discuss what the implications of public involvement were for issues such as accountability (i.e. in relation to targets) or for resourcing.

Interactions between Factors

The results of the review indicated that the factors discussed can interact and influence each other. This was demonstrated by the frequent overlap of factors discussed in individual publications. I interpreted that the majority of included publications (26) discussed multiple factors, with only three discussing one factor exclusively (Humphreys and Eisner, 2010; Thompson et al., 2017; Zahnow et al., 2018). These were quantitative studies focused on reporting patterns of change, with regards to single implementation factors.

Included studies particularly linked financial resources to other themes in this review, including partnership working, achieving or monitoring targets, or using evidence. For example, Thom and colleagues (2013a) reported that constrained resources influenced the governance of partnerships, with funding cuts made to partners' budgets being problematic for that actor's capacity to contribute to alcohol policy implementation. Additionally, Chalmers and colleagues (2016) found that complex funding arrangements for alcohol policy implementation hindered implementation work, because reporting for performance measurement (i.e. fulfilling accountability obligations) to these multiple funding sources required substantial time and resources from the recipient. Further, in New Zealand, Randerson and colleagues (2018) reported the most common barrier to opposing new alcohol licenses in the context of new legislation was the challenge of attaining sufficient evidence, in part because local areas sometimes did not have the resources to collect or generate it.

Various other interactions were also reported; for example it has already been noted in the section on partnership working that this approach to implementation can

complicate lines of accountability (Thom et al., 2013a). As a further example, Foster (2016) reported participants' perspectives within their data that development of local Statements of Licensing Policy in England should involve consulting the public, but also draw upon public health evidence.

The results of this review indicate the importance of remaining aware of, and understanding interactions between implementation factors in order to better explain and address implementation challenges. Given this, if a researcher wants to provide contributions to further explaining alcohol policy implementation, they need to accommodate the complexity of alcohol policy in their research design. As will be discussed in the following chapters, my research seeks to take forward this task.

3.4 Discussion

This chapter sought to review what is currently known from empirical studies about how national-level alcohol policies in high-income settings have been implemented, and why implementation occurred as it did. The results of this systematic review demonstrated that empirical literature about alcohol policy implementation in high-income countries is largely recent (majority of studies published since 2013), qualitative, and focused on the UK. The review found 29 relevant studies, often with a focus on particular aspects of alcohol policy implementation, for example on licensing systems in Scotland and England/Wales, and specific programmes such as the Alcohol Improvement Programme in England.

The factors which influence alcohol policy implementation can both facilitate or hinder implementation depending on the circumstances. While my analysis of the literature included a number of categories in which to organise the data, I generated three themes from these results that appeared to most often capture key aspects of how and why alcohol policy implementation occurs in high-income countries in the manner it does. These are: (i) accountability and governance; (ii) evidence use; and (iii) context and resources. I will discuss each of these in turn, explaining my findings, and considering what the implications of these are for my thesis and future research.

To inform my analysis, I will discuss the findings in relation to broader relevant literature, including from policy implementation, accountability and evidence use. I identified these literatures through iterative engagement with each, often starting with reviews of existing research or highly cited texts, in order to get a sense of critical contemporary debates in the field. I draw upon these in my discussion below, as well as in the results chapters to help inform my empirical analysis.

3.4.1 Accountability and Governance

I have brought together the categories of performance measurement, partnership working, and public involvement within the theme 'accountability and governance'. I did this because exploring these three areas with an accountability lens allows me to explore governance dimensions of these topics. Specifically, it gives me the opportunity to focus on governance-type questions that arise from these three categories, such as how the pervasiveness of partnership working in alcohol policy contexts appeared to be related to, and add complexity to, accountability in implementation.

Given this, I interpreted accountability and governance challenges to arise across the results primarily in implicit ways, signalled by the language used. For example, included publications discussed issues related to accountability in a variety of ways, including in terms of enforcement of alcohol policy (e.g. Casswell et al., 2018; Foster, 2016); responsibility (Fitzgerald et al., 2015; Lloyd et al., 2014; Martineau et al., 2014); monitoring and evaluating achievement of key targets or policy delivery (Parkes et al., 2011; Thom et al., 2013b; Toner et al., 2014), and using evidence to 'protect' a decision from scrutiny and appeal (Herring et al., 2008). These aspects of accountability were typically reported as a component of other implementation processes such as regulation and monitoring/evaluation, and did not explicitly link these findings to, or demonstrate consideration of, existing accountability literature (e.g. Bovens et al., 2014a).

The results identified that alcohol policy implementation is often occurring in environments in which there is a discourse around encouraging 'partnership working' and 'public involvement' in policy practice – key issues in contemporary governance. In particular, the results suggested that partnership working and public

involvement seemed to carry with them an assumption that 'more' of this way of working would be beneficial to local alcohol policy implementation, without necessarily explaining or justifying this assumption. However, results also indicated that the ability or efforts of different local areas to facilitate partnership working or public involvement had varied, with many challenges identified. For example, with the exception of Foster (2016) and Randerson et al. (2018), the included literature did not provide empirical examples of the benefits of public involvement. With respect to partnership working, the results of this review are aligned with an existing UK-based review which reported a lack of clear evidence of partnership working impacting on health outcomes (Smith et al., 2009). Developing understanding about this is critical given the proliferation of partnership working across the UK. Indeed, one of the contemporary challenges for policy implementation research is accounting for partnership working contexts.

Engagement with accountability literature may offer some potential to enhance understanding of alcohol policy implementation in high-income settings and support empirical analyses. For example, Fitzgerald and colleagues (2015) discussed the importance of clearly establishing responsibility for implementation interventions. They made this argument with regards to their perceptions of the national ABI target, determining that the target was useful because Health Boards were monitored about their performance against it and thus prioritised meeting it. However, there was perceived lack of clarity among interviewees about who had responsibility for meeting the target, which the authors found problematic. Lloyd et al. (2014) observed challenges experienced by Regional Alcohol Managers in England, who had to support the achievement of a 'hard' target (alcohol-related hospital admissions), without commensurate measures and resources to achieve this – these implementers had to rely on 'soft' methods of persuasion in their relationships with stakeholders such as Health Boards. This type of tension might be usefully examined analytically by drawing on concepts and ideas surrounding formal and informal accountability, and accountability in partnership contexts, which recognise these complex policy work environments (Romzek et al., 2013, 2012; Steets, 2010).

Further, given the results demonstrating that local alcohol policy implementers are often simultaneously navigating performance measurement, partnership working,

and public involvement responsibilities, contemporary literature on 'meaningful accountability' may be useful here (Bovens and Schillemans, 2014). The notion of meaningful accountability responds to critiques of the assumption about accountability that "there can never be too much of it" (Thomas, 2012, p. 673). This assumption is reflected in practice, in which one can observe examples of multiple, simultaneous, overlapping sets of expectations and accountabilities being applied to single organisations or policy programmes (Schillemans and Bovens, 2011). A focus on 'meaningful accountability' guides a researcher to investigate "questions about types of accountability and the conditions and contexts in which they are effective" (Bovens and Schillemans, 2014, p. 673). This is similar to Romzek and Dubnick's (1987) notion of 'appropriate' accountability, in which accountability systems are chosen and developed to fit with an organisation's tasks, strategy, and institutional context.

Reflecting on the results of this review in light of the above literature, there is an apparent need for research into the accountability 'regimes' of local alcohol policy implementers. An accountability regime is the "sum of all accountability relationships [actors] are required to manage" (Bovens et al., 2008, p. 226) and is useful for guiding the researcher to consider the multiple, and potentially overlapping accountability relationships borne from the need to meet performance measurements, work in partnership, and involve the public in decision-making. This literature also supports critical analysis of implementers' accountability regimes, in particular questioning whether a given regime is built on the assumption that 'more is better' or is reflective of knowledge about 'meaningful' accountability.

I acknowledge, however, that there are concerns about the analytical value of 'accountability' due to its 'chameleon-like' nature (Dubnick, 2005, p. 379; Flinders, 2014). I would argue that alcohol policy implementation researchers may find the concept analytically useful as long as it is clearly conceptualised and defined, because it otherwise risks being subject to existing critiques of being an amorphous, continuously widening, and imprecise concept. The definition I use, and how I conceptualise 'accountability', will be discussed in Chapter 5 (Section 5.1.1).

3.4.2 *Evidence Use*

Included literature appeared concerned with evidence use because of an underlying assumption that better use would improve the implementation work being studied. Included studies discussed evidence with varying depth and linked evidence use to implementation in both direct and indirect ways.

Analysis of included publications showed that, within alcohol policy implementation in high-income contexts, there are a range of types of evidence used and different approaches to evidence use. This appears partially explained by contextual factors, such as whether implementation was occurring in a licensing context in which licensing decision-makers had different perceptions of health-related evidence than public health actors. This creates a key challenge for alcohol policy implementation. If alcohol policy is considered intrinsically linked to alcohol-related harm, and this link has been established on the basis of existing public health evidence, it is problematic if a set of influential decision-makers do not agree with, give weight to, or otherwise 'believe' this evidence. This issue might be usefully explored through research which accesses licensing actors' perspectives first-hand, examining their patterns of evidence use and why public health evidence is apparently often not persuasive to them.

While included publications in this review have found that alcohol policy stakeholders use a range of evidence, these studies have either been focused on the English/Welsh context (e.g. in a specific setting of the Alcohol Improvement Programme, or a quantitative survey in England's licensing system), or based on a limited number of interviews with public health stakeholders who are discussing their perspectives on licensing actors' uses of evidence (Fitzgerald et al., 2017; MacGregor et al., 2013; Toner et al., 2014). Additionally, while the Scottish alcohol strategy itself has been lauded for being 'evidence-informed' (Fitzgerald and Angus, 2015), in-depth understanding of evidence-informed alcohol policy implementation in relation to this strategy is still required.

Indeed, while evidence use been identified in this review as playing a role in informing local actors' decision-making, this review highlights a need for further empirical work which analyses evidence use in alcohol policy implementation contexts. Included studies often examined how actors as individuals tended to use

or perceive evidence, more rarely attempting to empirically show how and whether patterns of evidence use emerge within or across organisations. Fitzgerald and colleagues (2017) have made a contribution here by pointing to potential 'cultures of evidence' among public health and licensing stakeholders.

Following this, in Scotland, the perceptions and uses of evidence by ADPs (and their diverse members) for alcohol policy implementation purposes requires greater empirical understanding. In particular, there appears to be a knowledge gap regarding how ADPs, in their structure as partnerships, are using evidence. Further, the literature has thus far provided limited explanation of, or ideas for how to address differences in perceptions of health-related evidence across public health and licensing contexts in Scotland. The existing literature does not yet seem to be able to explain why there appears to be such 'epistemological discord' (Nicholls, 2015) between public health and licensing actors in their approaches to evidence, what the role of other actors (e.g. in ADPs) is in all this, or how this tension might be overcome.

This knowledge gap is important because (assuming evidence use improves policy and processes) while a policy might be evidence-informed, if implementation is not then challenges may arise. Future studies in this area might be usefully informed by the much larger existing literature on the interplay between evidence and policy. This literature suggests, for example, that policy actors use a range of types of evidence in their work (Lorenc et al., 2014b; Oliver and de Vocht, 2015) and that there are a range of facilitators to evidence use (e.g. improving the timeliness or accessibility of research [Cairney, 2016; Hawkins and Parkhurst, 2016; Orton et al., 2011]). Further, the legitimacy and credibility that using evidence gives to decision-making (even if only symbolically) may also stimulate evidence use (Boswell, 2009).

3.4.3 Context and Resources

Context and resources were shown to influence the implementation of alcohol policy in high-income settings, with constrained resources being an important challenge to implementation. The results showed that alcohol policy is itself embedded in wider public health and social policy concerns, and is thus inextricably linked to social, political, and economic issues which surround alcohol use and related harms.

The issue of context spanned the different results categories and appeared to influence how local actors approached alcohol policy implementation. To illustrate, the initial results subsection highlighted the role of context in how implementers undertake the work required to ‘translate’ policy to their local area. Further, some studies reported that implementers perceived performance measurement targets were not fit for purpose, suggesting potential incongruence between the responsibilities of local implementers and the performance measurement structures they were embedded within. Additionally, a proliferation of partnership working across the UK, which requires implementers to engage in complex multi-sectoral collaboration, was an integral component of the alcohol policy context. The literature reported this went so far as to be embedded into the England/Wales licensing legislation (Foster, 2016; Herring et al., 2008), and it is broadly known similar emphasis on partnership working is present in the Scottish context (Cook, 2015).

Likewise, the issue of resources was relevant across my results although, in this case, it was still organisationally feasible to discuss them in a discrete subsection. The results indicated that sufficient, sustainable resources were critical for facilitating implementation, while a lack of resources, or reliance on multiple funding streams, presented important challenges. As a reminder, this problem was evident in the budget cuts and multiple funding sources for ADPs discussed and mapped in Chapter 2, suggesting it will be important for this thesis to pay attention to the role of resources in the implementation of Scotland’s alcohol strategy.

As the first review on this topic, there are no comparable syntheses for alcohol policy implementation. These aspects of my findings are unsurprising, given existing knowledge about the importance of context and resources for policy implementation (Hill and Hupe, 2014). However it is worth noting that only a minority of included studies explicitly referred to this broader policy implementation literature (Fitzgerald et al., 2017; Lloyd et al., 2014). This suggests that learning from policy implementation literature may be useful for better understanding issues being identified specifically in alcohol policy implementation. For example, writing within the UK context, Sausman and colleagues (2016) note the translation process that national policies undergo while being put into practice in distinct local contexts, stating, “policy is not implemented on a blank slate in a *de novo* context, but into an

existing network of practices and infrastructure which work to adapt and translate the policy” (p. 564). This observation appears to be aligned with what is currently known about the complex ways local implementers will be influenced by their local context when working to translate and ultimately enact alcohol policy.

The significance of contextual factors also suggested that alcohol policy implementers are navigating a balance between trying to effectively contextualise alcohol policy to local needs while meeting national expectations surrounding a centrally-developed policy, all while constrained by the (monetary and non-monetary) resources available to them. Again, this has been a persistent, complex situation in policy implementation research, which speaks to traditional debates in broader policy implementation literature about ‘top down’ control and enforcement of implementation, ‘bottom up’ discretion and contextualisation of policy directives, and synthesised perspectives (Gilson et al., 2018; Hill and Hupe, 2014; Hjern and Hull, 1982; Hjern and Porter, 1981; Nilsen et al., 2013; Owens and Bressers, 2013; Sabatier, 1986; Schofield, 2001).

These results suggest issues surrounding context and resources remain important considerations in empirical work on alcohol policy implementation. Given what is known about budget cuts experienced by Scottish ADPs, the influence of context and resources on implementation work, this thesis will pay attention to how context and resources interact with implementers’ (both ADPs and LBs) experiences of accountability and evidence use (explained further in Preface to Results).

3.4.4 Implications for Alcohol Policy Implementation Research: This Thesis

The findings of this review have identified research needs within alcohol policy implementation in Scotland, particularly with respect to accountability, evidence use, and the contexts in which implementation occurs. They also suggest my research would be usefully informed by knowledge from other literatures, and that drawing upon this knowledge would allow my research to demonstrate the potential added value of these literatures to alcohol policy implementation.

Specifically, this review identified that key areas requiring empirical consideration were accountability and governance, evidence use, and context and resources. The

important research gaps particularly related to: (i) how accountability relationships (e.g. between local and national government) are situated in the context of multiple other, overlapping accountability relationships; and (ii) how evidence is perceived and used at organisational-level and in partnership contexts. Issues related to context and resources were oft-discussed, appearing intertwined with other aspects of implementation. As such, these factors can be taken forward as a cross-cutting theme warranting careful consideration. This thesis will seek to contribute to understanding on these topics, and through a synthesis of key findings, contribute knowledge about local governance of Scottish alcohol policy implementation. How these themes help inform my research questions and empirical analysis will be detailed in the Preface to the Results (p. 139).

3.4.5 Limitations of Systematic Review

To my knowledge this was the first systematic review on alcohol policy implementation in high income settings – an important topic given what is known about the need for effective policy implementation to achieve outcomes.

Limitations of this review included its completion by a sole researcher; a collaborative team effort which provides greater strength to systematic reviews (e.g. for double screening or quality appraisal) was not feasible in this doctoral research project. Additionally, while search strategies were developed to try to be comprehensive while also feasible to screen, it is possible that publications discussing niche, specific areas of alcohol policy implementation were not captured by the searches. My screening of the reference lists of included studies, and my checks with others in the field, were intended to mitigate this as far as possible. Further, other exclusion criteria (such as requiring articles be written in English) may have led to the exclusion of relevant empirical work.

Certainly, the results of this review appear to be very UK-centric. This may have been a result of the keywords used in the search strings – it is possible I was not aware of certain terminology more readily used in other high-income contexts which would have resulted in more articles from outside the UK. Although I did check my search strings with others working in this field, they were also UK based and so may not be aware of terms used elsewhere. Additionally, my own preconceptions may

have influenced some of the more subjective decision-making regarding inclusion and exclusion of publications, including that I intended to carry out my own research on alcohol policy implementation in a Scottish context.

3.5 Conclusion

This chapter has presented a systematic review of alcohol policy implementation literature and positioned the thesis within this defined area of public health policy research. In doing so, this chapter has provided a systematic review of what is currently known about how alcohol policy implementation occurs in high-income contexts, and identified gaps, tensions and uncertainties in the included literature. The review synthesised available evidence to discuss the various factors that existing studies have identified as important to understanding alcohol policy implementation. I have argued that it is analytically useful to group these factors into three broader themes, each of which are revisited in the remainder of the thesis: (i) accountability and governance, (ii) evidence use, and (iii) context and resources. I discussed these in relation to relevant broader literature. The Preface to the Results (p. 139), which follows the methods chapter, will explain how the themes identified here will be taken forward in my empirical analysis.

4 Research Design and Data Analysis

4.1 Introduction

The purpose of this chapter is to describe and explain my research design and approach to analysis (beyond the systematic review, the approach for which was set out in Chapter 3 (p. 43-50)). This chapter first situates the thesis within a particular research approach. Second, I provide a reflexive account of how my position and background (e.g. as a public health-trained researcher, student, and project manager) informed key aspects of the design and conduct of this research. Third, I detail my decision to use a qualitative, embedded case study approach as the overarching framework for examining the implementation of Scotland's alcohol strategy. This includes some discussion of how I selected and recruited the three local areas which acted as my 'embedded sub-units' in this case study. Fourth, I discuss my decisions to use documentary analysis and semi-structured interviews as my methods of generating empirical data. For each, I provide a description and explanation of why I used the particular method, my approach to data generation, and the means by which I undertook data analysis. Additionally, I provide brief remarks about conducting observations of relevant meetings and events, which, while not used as formal empirical data, provided me with further contextual information about how Scotland's alcohol strategy was being implemented. Fifth, I discuss my research ethics and reflect upon enacting ethical research. Finally, I discuss considerations related to quality control of my research, including my efforts to undertake 'member-checking' of my preliminary findings with participants and the limitations of my chosen research approach.

4.2 Research Philosophy and Inspiration for Research

4.2.1 Interpretivist approach and Policy 'Practice'

This research is grounded in an interpretivist approach, which perceives humans to make, interpret, and communicate meaning as they navigate the world and its innumerable contexts (Yanow, 1996). Put simply, as a researcher, I perceived participants to be interpreters of their own experiences, and my role was then to interpret and report their interpretations (Yanow, 2007). I was therefore guided in this research to continuously emphasise the importance of mine and my

participants' "own interpretations of the issue researched" as "[our] varying vantage points will yield different types of understanding" (Ritchie et al., 2013, p.21). This approach was evident in my decisions about how knowledge and meaning could be accessed, generated, understood and explained. This distinguishes my approach from more objectivist approaches to knowledge which suggest the possibility of accessing a singular, verifiable, and generalisable truth about an external reality (Schwartz-Shea and Yanow, 2012).

For example, as I undertook this research, I explicitly incorporated attention to context and I used research methods which encouraged engagement with subjective representations of participant experiences (Yanow, 2007). I was particularly cognisant of Yanow's articulation of interpretive policy analysis of national social policy implementation as being concerned not with the success of a policy, but with understanding *how a policy 'means'* (Yanow, 1996) – essentially how someone makes sense of and generates meaning from a policy when they engage with it. In other words, a policy, and its implementation, is understood and enacted "according to the meanings it takes on when it is interpreted by actors who are involved" (Papanastasiou, 2015, p. 58). In light of the above, I view my analysis as interpretive.

Within this approach, I situated my research in the (diverse) tradition of policy studies which conceptualise policy (and its administration, or more broadly, governance) as 'practice' or 'work' (Clarke, 2012; Colebatch, 2006; Freeman et al., 2011; Wagenaar, 2004; Wagenaar and Cook, 2003). Because my interest was in empirically exploring what alcohol policy implementers *do* to enact alcohol policy, I was aiming to make explicit and generate meaning from the everyday *policy practice* of local alcohol policy implementers. Therefore, I subscribed to Wagenaar's view of policy practice as "the everyday, taken-for-granted routines and practices, the explicit and tacit knowledge that is brought to bear on concrete situations" (Wagenaar, 2004, p. 644). This perspective was useful for its integration of practice, corresponding knowledge (conceptualised broadly) and context (Cook and Wagenaar, 2012). For example, throughout this thesis I refer to alcohol policy implementation carried out by local policy actors (e.g. ADP members) as 'practice' or 'work'. I conceptualise this work as addressing policy problems which are "constituted in the complex detail of local situations, endowed with meaning...and

continuously unfolding in the enactment of concrete practices” (Wagenaar and Cook, 2003, p. 170).

4.2.2 Reflexivity and my approach to studying alcohol policy implementation in Scotland

Reflexivity is an ongoing process in which the researcher undergoes ‘critical self-evaluation’ of their positionality and “active acknowledgement and explicit recognition that this position may affect the research process and outcome” (Berger, 2015, p. 220). It requires the researcher to make a constant commitment to critically considering and making explicit how their own knowledge, experiences, and self are situated within the research (i.e. the researcher is *part of*, not separate from the research) and then how these may be impacting the research as a whole (Berger, 2015). This is intended to help enhance the transparency of qualitative research and ultimately its credibility or trustworthiness (Cutcliffe, 2003). In committing to being reflexive, the researcher acknowledges that research is contextual, and that their production of knowledge through their research is not neutral or independent of them (i.e. is not ‘objective’) (Berger, 2015; Buckner, 2005). Important to note, however, is the difficulty presented by the fact that the researcher undertakes this commitment but cannot fully know all aspects of their self and how this may shape the research (Rose, 1997).

Making a commitment to reflexivity in my own research was important because it is a “central feature of [interpretive] methodological checks on sense-making” (Schwartz-Shea and Yanow, 2012, p. 98). In light of this, I recognise that my research plans, aim, and design were necessarily influenced by my professional (and other) experiences, values, preconceived notions, educational training (etc.) which I brought to this research. Further, the interviewees within my research were interpreting the world in which they work, as was I, and together we co-generated the evidence I discuss in this thesis. Thus, reflecting on my own positionality and assumptions which may have influenced my decisions, actions, and interpretations was crucial.

My journey to an interpretivist approach happened over time. Having come to the University of Edinburgh directly from WHO, I arrived with a viewpoint shaped by how I observed WHO to be seemingly ‘hovering’ above or around the work of Member

States with whom WHO worked, aiming to support the development and implementation of policies and guidance. This shaped my initial perceptions about the problem of alcohol policy implementation and 'implementation failure' – essentially as one situated in hierarchical bureaucracies, in which policy and legislative 'artefacts' and ideas are developed near the 'top' and are implemented by officials at sub-national or local levels. For example, to begin learning about alcohol policy implementation in Scotland, I started by accessing the problem through the formal, governmental institutions I perceived to be most relevant to the problem (i.e. Scottish Government and NHS Health Scotland). I did this through multiple, informal 'scoping' meetings mostly with national-level stakeholders (discussed further below). I also engaged with literatures which explained alcohol policy implementation in terms which, at the time, resonated with my professional observations and experiences – for example, literature which debated 'top down' and 'bottom up' approaches to policy implementation. As I progressed with my research, however, my thinking began to change. For instance, I began to appreciate the need to interview local stakeholders beyond public health who could offer different perspectives on Scottish alcohol policy implementation. I also noticed that, as I engaged more with critical public health policy, accountability, and evidence use literature, publications which seemed to take an interpretivist approach were particularly interesting, and consequently influenced my research design and analysis (e.g. Bacchi, 2015; Baum, 1995; Baum and Fisher, 2014; Katikireddi et al., 2014; Smith, 2013). I took similar inspiration from methodological literature which was positioned within an interpretivist tradition (e.g. Braun and Clarke, 2013; Ritchie et al., 2013), finding that their approaches to undertaking research strongly resonated with how I was seeking to make sense of and explore my research problem.

When I developed this research project, my initial aim was to study a national health policy that was a) intended to prevent and address non-communicable disease, and b) related to health inequalities. I wanted to use this type of policy as a vehicle through which to study how national health policies are implemented in local areas because I was interested in why policies often did not have their intended impact. This interest stemmed from my academic and professional background, which had often been focused on policies developed to support vulnerable populations, such as those experiencing mental health problems or addiction. I had observed,

however, that these policies were often not successful in achieving their stated goals, resulting in their target populations continuing to suffer. Having by then undertaken studies during which I learned about policy development, I questioned how useful it would be to focus primarily on how policies were made, to the exclusion of their implementation. I was keen to explore this issue in a policy area with which I was already familiar and passionate about.

At a critical moment in my planning, I spoke with Dr Erica Wimbush (at the time Head of Evaluation for NHS Health Scotland) who suggested that the Scottish Government's response to alcohol-related health problems could be suitable. Having worked on the topic of alcohol previously, and after familiarising myself with the multi-faceted Scottish alcohol strategy, I decided that this government strategy was a viable focus for this research.

Similar to my interest in implementation discussed above, my interest in alcohol policy was also shaped by my previous work and research in mental health and substance abuse. This included work at WHO to support a project developing online ABIs, and earlier research studies related to alcohol use and public policy for my undergraduate and master's degrees. During these experiences I observed not only the public health impact of alcohol but also the way the topic of alcohol and related harms was relevant to other policy areas (for example, economy or justice). Noticing the ways people from different policy perspectives approached the topic of alcohol helped me realise it would be important to understand how different actors interpreted and implemented alcohol policies.

My previous work and studies influenced the normative assumptions I held during my research, such as assuming that health impacts of alcohol use should be prioritised over the economic case for alcohol production and sales. For example, this became evident in my research design, when I started by framing the research 'problem' of implementation as one which explores how Scottish alcohol policy can better mitigate alcohol-related harms. It was also apparent in my interactions with stakeholders and analysis. Trying to establish myself as part of the public health community in Scotland, I developed connections with key advocacy groups such as AFS, and academics and other stakeholders who approached alcohol policy from a public health perspective. In my analysis, I was more likely to question economic

arguments related to alcohol licensing than health-related ones, and to interrogate government-industry collaborations than government-civil society ones.

I also came to realise I had brought a government-centric understanding of governance to my research. Alcohol policy implementation, conceptualised broadly, could be explored by studying a range of actors' roles and perceptions. However, I conducted my study with a focus on local and national government (or other public service) actors and my data generation shows only limited direct engagement with third sector or private sector actors. Despite this, I did engage with Alcohol Focus Scotland at national level, and interviewed local third sector actors when they were members of ADPs. Additionally, my operationalisation of what a 'policy' was in this research was quite state-centric – my decision to focus on Scottish Government's strategy illustrates this, as does my systematic review (Chapter 3) which focused on government-developed policies. This approach was again likely influenced by my own perceptions and experiences. For example, as a public health and social policy graduate, my educational training had often focused on governments' responsibilities for providing health services to their populations (within the context of the broader welfare state). At WHO I observed our work had often considered Member States' governments to be primarily responsible for population health.

Reflecting the assumptions discussed above, early developments in my research design were influenced by my interactions with government actors and health advocates. Early in this project I worked to ensure my research design was informed by 11 informal 'scoping' meetings with national- and local-level stakeholders in early 2015 (see Appendix 2). The purpose of these meetings was information gathering so they were not recorded or analysed; each conversation served to inform my thinking about this research project, familiarising me with relevant contexts, actors, institutions, and processes. I particularly wanted to understand how this PhD research could complement the existing evaluation work carried out by MESAS (see Chapter 2), and speaking with MESAS representatives proved particularly useful in my planning.

A reflection from these meetings was the perceived variation in local implementation of Scotland's alcohol strategy across different local areas. This variation included, for example, the interpretation of policy and legislation, the uses of resources, and

local needs and outcomes. To capture potentially rich understanding resulting from this variation, I perceived my research design would be strengthened by generating data in multiple local areas (see Section 4.3.2).

My research was also likely shaped by the specific context of its funding. For example, the fact that my doctoral studies were funded via What Works Scotland was undoubtedly relevant to both the geographical and analytical foci of the project. While this could have felt like a constraint, I perceived this as an opportunity for pragmatic and strategic reasons. For example, doing fieldwork in the country in which I was living was more feasible and flexible than fieldwork overseas, and I anticipated opportunities for connecting with the What Works Scotland team and broader network – connections which could potentially facilitate my research (e.g. in relation to choosing local areas with which to work, see Section 4.3.2). Further, What Works Scotland focused on helping to improve local policy and public services (What Works Scotland, 2019) and this study of alcohol policy seemed an appropriate contribution to make as a student funded by this programme.

Saying this, however, my research proceeded quite independently from What Works. For example, What Works Scotland took a ‘collaborative action research’ approach which prioritises the collaboration of researchers and public services practitioners in conducting (and then acting upon) the research (What Works Scotland, 2020). Given the independent nature of doctoral research I did not perceive this approach to be suitable for my purposes, but my connection with What Works Scotland did help shape my thinking in terms of appreciating the importance of local actors’ perspectives on policy and the usefulness of academic research.

Reflecting overall on this thesis and the academic process, this research developed out of my personal interest in how national policies become local realities. It involved bringing my own research and public health policy experience to my data generation and analysis, and was designed so I could engage directly with national and local policy decision-makers to investigate my identified research problem on alcohol policy implementation. This design provided the opportunity to undertake research which consistently remained grounded in policy and policy stakeholders’ experiences. However, it also gave rise to important challenges. Researching the topic of alcohol policy implementation meant I had to straddle multiple academic

disciplines, including public health, public policy and administration, and evidence and policy, which often bring different lenses to a health policy problem. I needed to consider the different process-related domains which intersected and helped me explain the empirical phenomena I analysed, including policy implementation and other policy work, public administration/bureaucracy, and politics. The delicate balancing of these academic and practical policy influences made for a challenging, but rich and interesting research project.

4.3 Planning and Using a Qualitative Embedded Case Study Approach

4.3.1 Selecting an Embedded Case Study

I decided to pursue my research questions through qualitative methods. This was because they reflected my motivation to deeply explore stakeholders' perspectives about how Scotland's 2009 alcohol strategy was implemented and why implementation occurred the way it did. I selected a case study as the overarching methodological approach, the full rationale for which is explained below. I rejected more intensive approaches, such as ethnography, because the process of alcohol policy implementation in ADPs occurred across too many organisational locations for this to seem feasible without sacrificing the chance to study multiple local contexts.

The embedded case study approach permitted in-depth inquiry into the 2009 alcohol strategy, and explicitly encouraged that the research be conducted within the policy's context (Yin, 2009). This was important because, to understand how the strategy was implemented, I needed to interact with officials conducting this implementation work in their contexts. It also provided a way to attain the 'thick' description necessary to contribute in-depth, nuanced knowledge about the complexity of alcohol policy implementation (Gerring, 2004; Yin, 2009). Further, it was suited to the 'how'-oriented research questions which structured the project, and could accommodate different qualitative methods of data generation (Simons, 2009).

I chose an embedded case study design, because its' design consists of a single, overarching case of interest, which is examined through the use of multiple sub-units of analysis, all placed in (and interacting with) its context(s) (Scholz and Tietje,

2002; Yin, 2009). Taking an embedded case study approach structured the research such that learning from the sub-units would be synthesised, and then, importantly, linked to national-level decision-making.

This design provided the flexibility to incorporate different local areas and levels of governance. Given the initial information I attained from scoping meetings about perceived local variations in the strategy's implementation, I felt it was important to study multiple local areas³¹ with a view to understanding more about how implementation was occurring in different contexts. I wanted to ensure a variety of different settings and perspectives were represented (Stake, 2000), and so I opted not to undertake a traditional single case study design since that would have provided insight into implementation in one only local area was (discussed further below, Section 4.3.2).

My research did not constitute a 'multiple case study' which relies on considering multiple 'cases' individually (Yin, 2009), because I was focused on the implementation of a single, national alcohol strategy and wanted to capture local variations. Since my analysis of the three local areas was all undertaken with reference to this overarching case, each was effectively a sub-unit of analysis, contributing knowledge for the same case study. While, for practical reasons, I conducted data generation in each location sequentially, in my analysis I primarily combined the data from all sites to explore in-depth key themes across the three locations (see Chapters 5-7).

A key strength of case studies is their ability to allow for (indeed, best practices typically demand) multiple methods and sources of data generation (Ritchie et al., 2013; Yin, 2009). This provides the researcher with flexibility to select methods best suited to addressing their research questions. As detailed further below, I used semi-structured interviews to engage with first-hand accounts and perceptions of alcohol policy stakeholders. I also used analysis of policy documents to attain official, statements by government, which represented their framing of the policy problem and expectations about its solutions (Freeman and Maybin, 2011).

³¹ Local areas generally correspond to the geographical borders of Local Authority areas in Scotland, however the term 'local areas' is appropriate here because ADPs sometimes do not correspond perfectly to these borders.

4.3.2 *Choosing Sub-Units and Negotiating Access: Three Scottish Local Areas*

To choose three of the 32 local areas in Scotland as the embedded sub-units for this research project, I took inspiration from Miles and Huberman's (1994) case selection framework. This framework suggests that *a priori* purposeful 'sampling' of geographical locations for qualitative research should be based on six criteria, including the researchers' conceptual framework, potential of the location to generate rich information, and whether the sample strategy is feasible. I did not employ this framework as a formal 'sampling strategy' (employing the idea of 'sampling' or 'generalisability of learning' would have diverged from my interpretivist approach [Schwartz-Shea and Yanow, 2012]). However, I found some of Miles and Huberman's suggestions useful as prompts to stimulate my thinking about how I wanted to choose and (feasibly and productively) access local areas for this research.

In seeking areas which would collectively generate rich information, I wanted 'exposure' (Schwartz-Shea and Yanow, 2012, p. 85) to a variety of settings in which the alcohol strategy was being implemented, in an effort to access the potentially diverse meanings local implementers were developing across different contextual settings. In selecting the three local areas, I sought to "encapsulate a *relevant range* in relation to the wider universe, but not to represent it directly" (Mason, 2002, p. 124, emphasis in original). I therefore chose areas which were varied in terms of: (i) their status as urban, rural, or mixed urban-rural; and (ii) whether their local area's ADP was situated within the Council or Health Board. Regarding the former characteristic, I perceived that local areas' priorities and approaches to implementing key local aspects of the strategy (e.g. planning alcohol services) would potentially reflect their geography (and the challenges geography might present, especially in rural areas). This did become apparent in my local interviews, and I mention this in my results chapters. Regarding ADPs' locations³², I wanted the opportunity to observe how local implementers' experiences varied depending on where they were positioned within local governance structures. However, in my data

³² The decision of where to locate each ADP would have been made at a local governance level

this characteristic did not appear to have a meaningful influence. This may have been in part because of recent local health and social care integration³³, which possibly meant ADPs' location in either health or the council became less important or less distinct. I therefore do not comment further on this characteristic of ADPs in the results.

Regarding feasibility, I perceived that three areas would be a manageable number given the time and resources I had available to me, without unacceptably compromising the depth of my analysis in each area. I also carefully considered which areas would be feasible for me to access during fieldwork, given my status as a sole researcher with limited time and financial resources. I decided not to include any local areas which I perceived to be inaccessible (including those where I could not feasibly visit multiple times) given my restricted resources.

I also considered how my positionality as a PhD student funded by What Works Scotland would potentially help or hinder negotiating access to local areas. Given that a number of Local Authorities (~15) in Scotland had applied to participate in the collaborative action research work portfolio of What Works Scotland in the months prior to my starting this research, I considered that these areas may also be open to allowing me access for my own research. Further, in their applications to What Works Scotland, the areas identified their local policy priorities. Many of these were related to health and/or alcohol policy, and I took this as an indication of which local areas may be open to engaging with my alcohol-related research. I therefore used this as an additional consideration when choosing the local areas.

4.3.3 *Negotiating Access to Case Study Areas*

I ultimately sought access to one urban, one rural, and one mixed urban-rural site (Table 4.1). Two of the areas situated their ADP's administrative teams in the Local

³³ During this research, local areas were navigating new changes to local governance caused by the enactment of *the Public Bodies (Joint Working) (Scotland) Act 2014* (Scottish Parliament, 2014a), the legislation that triggered formal health and social care integration in Scotland. In doing so, the legislation aimed to enhance joint working between NHS boards and local authorities (and thus improve quality of services and achieve efficiencies), by creating new public organisations called 'integration authorities' (Burgess, 2016). This Act commenced in April 2015, and all integration authorities had to be operational by April 2016 (Audit Scotland, 2015).

Council, and the other in the local Health Board. The three sites were accessible and affordable in terms of transport and accommodation, and having engaged with their local policy documents (available online), I perceived they would be ‘information-rich’ areas in which to explore my research topic (Miles and Huberman, 1994). This subsection describes how I sought access to the three areas, which laid the groundwork for recruiting individual interviewees in each. Recruitment of national level interviewees is discussed in Section 4.6.

Table 4.1 Urban/Rural Classification of Included Local Areas

Local Area	Scottish Government
Local Area 1 (LA1)	Urban Area
Local Area 2 (LA2)	Other Urban Areas & Accessible Small Towns
Local Area 3 (LA3)	Remote Rural & Other Urban Area
*Classification labels provided as per Scottish Government Classifications	

I approached the three selected sites sequentially. I made this decision because: (1) a sequential approach gave me the opportunity to use the first area as a ‘pilot’, and bring learning I gleaned from my experiences with this area in the other two; (2) the geographical distances between each area meant that it was more feasible, in terms of time and cost, to visit each in turn instead of bouncing between them; and (3) working with one site at a time allowed me to focus on and engage deeply with the work occurring in that particular site, avoiding potential cross-site confusion during data generation. I have labelled these areas LA1, LA2, and LA3 in temporal sequence, and refer to them in this way throughout this thesis.

I understood that effectively accessing each local area would be contingent on, for example, the setting, the local actors with whom I was trying to engage, the particular pressures they were experiencing, and their perceptions of me as a researcher and of my research (Schwartz-Shea and Yanow, 2012). To begin developing relationships and seeking access, I first focused on each local area’s ADP as the key local organisation / body tasked with implementing Scotland’s alcohol strategy. I approached each ADP through their Coordinator, an individual employed full time to coordinate the ADP, and who I perceived to be an important gatekeeper. Initial contact with each Coordinator was via email. Through the ADP coordinators, I secured agreement from each ADP’s core decision-making group

(named, for example, their 'Executive' or Strategic Team) to participate in this research.

I was fortunate in this process that all of my initially chosen local areas agreed to grant me access after conferring with their members. Although it is difficult to pinpoint exactly what caused their unanimous positive responses, it may have been a combination of social and contextual aspects of the research process (Schwartz-Shea and Yanow, 2012). This may have included my initial contact with the ADP Coordinators, the timing of the project during the 'refresh' of the *Framework for Action*, a perceived general willingness of local implementers to participate in this type of research, and/or my links to What Works Scotland.

Once each local area had granted me access, and I had obtained the necessary research ethics approvals (see Section 4.9), I proceeded with 'recruiting' individual interviewees and generation of interview data. The following sections discuss my approaches to generating and analysing documentary and interview data.

4.4 Documentary Analysis: Rationale and Approach

4.4.1 Selecting Documentary Analysis

By engaging with documents in qualitative research, a researcher can enhance their explorations and understandings of a topic in a variety of ways. This includes using the documents to interpret and learn about the contexts relevant to their research, identify actors or agencies, access knowledge and representations about authors' individual or collective meanings and decisions, or observe changes over time (Bowen, 2009). My decision to use documentary analysis followed authors such as Freeman and Maybin (2011) in seeing documents as critical to thinking about and studying policy processes, and Iannantuono and Eyles (1997), who note that the language in policy documents help a researcher to access "diverse and dominant meanings" in policy (p. 1612). Further, like Mason (2002) and other authors, I felt that the content of key policy documents would provide meaningful evidence and constructed representations of official, collective decisions taken by those with authority in the Scottish alcohol policy system, as well as the values underlying these policy decisions (Schwartz-Shea and Yanow, 2012; Simons, 2009). Pragmatically, I perceived that (i) accessing documents would be relatively

straightforward and not resource-intensive (Bowen, 2009; Ritchie et al., 2013; Shaw et al., 2004) given the availability of national policies and legislation online, and (ii) they would potentially provide a relatively linear, coherent narrative which represented what would have been a complex process of discussion and negotiation among a plurality of stakeholders (Fitzgerald, 2007; Ritchie et al., 2013).

It follows that, in my research, each relevant national policy document was a comparatively 'stable' source of data which constituted a "critical moment or node" (Freeman, 2006, p. 52) that I, and interviewees, could discuss and reference. Importantly, the documents provided formal documentation of how their authors (e.g. Scottish Government, Parliament, and senior civil servants) framed the problem of alcohol-related harm in Scotland and the potential solutions for addressing it (Freeman, 2006). In my selected case study, key policy decisions had already been made and formalised by virtue of being officially documented, therefore analysing these documents was crucial for accessing information about the national policy decisions which had already occurred and expectations regarding implementation (and so I could analyse how well they matched what I observed in local interviews). However, there were also potential problems related to using official documents. For example, there were no guarantees they would discuss the topics and issues I was interested in, or address them in sufficient detail or depth (Bowen, 2009; Shaw et al., 2004). Further, being a written text meant I could not attain clarification from a document the way one can in an interview with a person, via dialogue (Schwartz-Shea and Yanow, 2012).

Data from documents (Table 4.2) also helped me to better understand the interpretations and responses of local level implementers/interviewees in relation to the national documents. These data helped me explore and compare how these documents connected the actors within ADPs by bringing them together in partnership to implement the alcohol strategy, and coordinated their actions by outlining policy expectations (Freeman, 2006). Overall, I perceived that the policy implementation work of local implementers would be at least in part constituted via their engagement with the relevant national policy documents. Understanding these therefore seemed critical to my analysis.

Following the above, my two chosen methods of documentary analysis and semi-structured interviews were selected both for their logical fit with my research questions and for how they could complement one another. This is in terms of the access to knowledge each research method could provide, and the way they could improve the ‘intertextuality’ of the evidence I generated (Bowen, 2009; Schwartz-Shea and Yanow, 2012). In other words, by treating documents and interviews as each having value, and by engaging in intertextual reading across these sources of evidence, I could generate opportunities for observing ambiguities, contradictions, or consensus across reported experiences of implementing Scotland’s alcohol strategy. Thus, in this project I followed researchers who position documents as having rather greater intrinsic value (as opposed to how they are represented by Yin (2009), who states, “the most important use of documents is to corroborate and augment evidence from other sources” (p. 103)). I also agreed with researchers who advocated for the use of more than one method of data generation, in order to access different situated knowledges and enhance the quality of the research (e.g. Bazeley, 2013; Hope and Waterman, 2003; Noble and Smith, 2015; Rolfe, 2006).

4.4.2 Data Generation: Documentary Sources

I decided to analyse and report on national policy documents which would contribute to my understanding of Scotland’s alcohol strategy and the policy/legislative context surrounding it. As noted, ADPs were responsible for developing their own local strategies, which outline how they would pursue and achieve agreed local outcomes. While I read each local strategy developed by my included local areas (all available online), I did not formally analyse or report on them here so as to preserve the anonymity of each area.

I analysed 16 national policy, legislative, or guidance documents (Table 4.2), all of which were publicly available online. The identification of potentially relevant documents occurred through searching key government websites (including searching for Scottish legislation with keyword ‘alcohol’ in the UK’s online legislation database³⁴); reading relevant academic and grey literature (e.g. MESAS reports); and speaking with key stakeholders during scoping interviews and formal semi-structured interviews. Through the process of selecting and analysing documents, I

³⁴ legislation.gov.uk

noted that they varied in the richness of their relevant content, and what knowledge they provided in relation to the implementation of Scotland's alcohol strategy.

Below I briefly explain my decisions to include these documents, and use heuristic groupings for the purposes of organising my explanations in this subsection. These groupings represent my own interpretations of them, and I do not suggest that any grouping or its members would be 'fixed'. However, these groupings were useful because the documents I analysed seemed to have varying significance to and types of impact for the actual work of implementing Scotland's alcohol strategy (e.g. because of their legal or administrative weight, or how much they focus on alcohol policy and services). For example, legislation has direct legal bearing on the actions of implementers, while a document such as the *Commission on the Future Delivery of Public Service's* ("Christie Commission") seemed, at the time of my research, to serve more as a normative guide to implementation practice. This was illustrated in the data from interviews:

"I wasn't mandated or tasked to take it on in my job, but just that pressure that you feel when you read something like the Christie Commission and you think 'yeah I'm part of this, and we need to start being part of it'." (LA1, ADP Member)

As a result, any linking of the expectations from these documents to interview data needed to consider how influential each document could have been on the implementation of Scotland's alcohol strategy at the time of my research by virtue of how it was developed and the form it took. I acknowledge, however, that the significance of a given document on implementation of the strategy is likely to have been fluid and situated in the time and local areas in which I conducted this research (Schwartz-Shea and Yanow, 2012).

Table 4.2 Legislation and policy documents selected for analysis, (by type and date)

	Name	Author	Date	Brief Description as Related to Alcohol Policy
	Legislation			
1	Licensing (Scotland) Act	Scottish Parliament	2005 (enacted 2009)	<i>Core document</i> ; sets out licensing objectives including 'public health'.
2	Alcohol etc. (Scotland) Act	Scottish Parliament	2010 (enacted 2011)	<i>Supplementary document</i> ; Introduces Health Board as a mandatory consultee on Licensing Board's Licensing Policy Statement and for all premises applications.
3	Criminal Justice and Licensing (Scotland) Act 2010 (Part 9 on alcohol licensing)	Scottish Parliament	2010	<i>Supplementary document</i> ; modifies Licensing Act 2005 provisions regarding, for example, premises licence applications and powers of Licensing Standards Officers
4	Public Bodies (Joint Working) (Scotland) Act	Scottish Parliament	2014	<i>Contextual document</i> ; triggered formal health and social care integration, with implications for ADPs
5	Air Weapons & Licensing (Scotland) Act	Scottish Parliament	2015	<i>Supplementary document</i> : Makes provision for updated rules and regulations surrounding alcohol licensing, including mandating Licensing Boards submit annual financial and functions reports.
6	Community Empowerment (Scotland) Act	Scottish Parliament	2015	<i>Contextual document</i> ; gives new rights to communities and duties to public sector, with possible implications for ADPs.
	Policy and Guidance			
7	Licensing (Scotland) Act 2005 – Section 142 – Guidance for Licensing Boards	Scottish Executive	2007	<i>Core document</i> ; outlines guidance for Licensing Boards as to the exercise of their functions under the Licensing Act 2005
8	Changing Scotland's Relationship with Alcohol: A Framework for Action	Scottish Government	2009	<i>Core document</i> ; central policy of Scotland's alcohol strategy
9	Delivering Better Outcomes: An Outcomes Toolkit for Alcohol and Drugs Partnerships	Scottish Government	2009	<i>Supplementary document</i> ; provides guidance to ADPs about 'operating in an outcomes based environment'
10	A New Framework for Local Partnerships on Alcohol and Drugs	Scottish Government, COSLA, NHS Scotland	2009	<i>Supplementary document</i> ; previous version of key guidance for ADPs
11	The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services	COSLA, Scottish Government	2014	<i>Supplementary document</i> ; outlines Government's alcohol and drugs quality improvement framework for services, and data required to evidence outcomes

12	Updated Guidance for Alcohol & Drug Partnerships (ADPs) on Planning & Reporting Arrangements	Scottish Government, COSLA, NHS Scotland	2015	<i>Core document</i> , updates 2009 'New Framework'; sets out working arrangements of ADPs, intended to support performance measurement
13	Supporting Alcohol and Drug Partnerships to Deliver Improved Outcomes for Alcohol and Drugs: 2016-17 Funding Allocations	Scottish Government official (Kleinberg)	2016	<i>Supplementary document</i> ; Letter regarding funding allocations was received by ADPs in July 2016 from the Acting Head of Health Improvement and Equality in the Scottish Government
14	Letter to ADP Chairs	Scottish Government official (Kleinberg)	2017	<i>Supplementary document</i> ; Letter regarding funding transfer to NHS Boards' baseline budget was received by ADPs in January 2017 from the Head of Health Improvement in the Scottish Government
15	Supporting the Delivery of Alcohol and Drug Services: 2018-19 Ministerial Priorities and Funding Allocations	Scottish Government official (Kleinberg)	2018	<i>Supplementary document</i> ; Letter regarding Ministerial priorities and funding allocations was received by ADPs in May 2018 from Deputy Director, Health Improvement Division in the Scottish Government
Commissions				
16	Commission on the Future Delivery of Public Services ("Christie Commission")	Dr Campbell Christie CBE	2011	<i>Contextual document</i> ; makes recommendations for reforming Scotland's public services

First, I interpreted that there was a set of 'core' documents, such as the *Framework for Action* (2009) or *Licensing Act* (2005), that were a particularly rich source of knowledge because they specifically outlined actions or guidelines for Scotland's alcohol strategy. As discussed in Chapter 2, the *Framework for Action* (2009) provides a strategic policy mandate for actions to "rebalance Scotland's relationship with alcohol" (Scottish Government, 2009a, p. 4). Such documents appeared in my initial scoping of alcohol policy literature and other sources such as government websites, and were mentioned explicitly in my interviews.

Second, a set of 'supplementary' documents, seemed to still clearly relate to alcohol policy, but appeared to augment the aims and activities of the *Framework for Action* and its implementation. These include, for example, *The Quality Principles*, which were published in 2014 and are specific to alcohol and drugs services (Scottish Government, 2014b). *The Quality Principles* are intended to: "support and drive a

culture of self-assessment whereby services are commissioned based on evidence of meeting principles of care, which will be measured by a range of tools including an agreed set of quality indicators of recovery” (Scottish Government, 2014b, p. 5). All ADPs were expected to implement these, and progress was monitored by an organisation called the Care Inspectorate (Care Inspectorate, 2017; COSLA et al., 2015).

Third, there was an important set of ‘contextual’ documents which, while they did not focus on alcohol specifically, were discussed in the interviews and seemed to have an explicit influence on the local governance context in which ADPs were situated (e.g. surrounding community planning or the integration of health and social care). I reflect here that the way such documents seemed to shape the context in which implementation was occurring was sometimes more interesting and discernible than the influence of certain ‘supplementary’ alcohol legislation (e.g. the *Criminal Justice and Licensing (Scotland) Act 2010*). As an example, the Christie Commission (Christie, 2011) identified key principles for public service reform in Scotland, including prioritising prevention and integrating service provision. Both of these themes arose frequently in interviews conducted during this research, as being prioritised for local alcohol policy implementers. Other examples included the *Public Bodies (Joint Working) (Scotland) Act* (Scottish Parliament, 2014a) and the *Community Empowerment (Scotland) Act* (Scottish Parliament, 2015b) (Chapter 2).

4.4.3 Analysis of Documentary Data

To analyse the documents, I sought approaches consistent with an interpretive, qualitative research project. An example approach available to me, therefore, was thematic content analysis, which allows a researcher to examine how ideas and concepts were developed, discussed, represented and communicated within the documents (Smith, 2008). I decided to follow authors such as Bowen (2009) and Braun and Clarke (2013) in their use of thematic analysis. This approach was suitable to exploring the meaning within the different types of documents, and to comparing and reading across my analyses of the documents and the interviews.

To develop my approach to thematically analysing each document, I drew on Walt and Gilson's (1994) Triangle Framework for health policy analysis as an

organisational device to plan key dimensions of my analysis. I was drawn to Walt and Gilson's work because the authors' explanation of their framework paid attention to issues of policy implementation. Further, their four categories of actors, context, process, and content were each obviously relevant for understanding how Scotland's alcohol strategy and its implementation were represented in these documents. I was particularly drawn to the inclusion of 'processes', which drew attention to, for example, how policy actors navigate various (and sometimes competing) expectations and make decisions. Given my engagement with relevant literature and knowledge from my local interviews, these types of process issues seemed to be particularly interesting and important in the context of Scottish alcohol policy implementation. The authors are explicit that their framework is a "highly simplified model of an extremely complex set of interrelationships" (Walt and Gilson, 1994, p. 355), and indicated that specific detail and depth must be added by the analyst.

Given this, I used Walt and Gilson's categories as a starting point from which to think through how I wanted to engage with the documents and generate knowledge from them. I used my reading of the *Framework for Action, Christie Commission*, and *Licensing Act 2005* to begin developing a series of questions which guided my analysis (Table 4.3). I also followed authors such as Braun and Clarke (2013) and Bowen (2009) by drawing on knowledge I was generating from early analysis of local-level interviews. This included ideas about key themes which seemed to be emerging in the interviews. As an example, uncertainties about the role of ADPs which were evident in the interviews led me to include a question which explored this issue in the documents. This process was also informed by the methodological literature, which prompted some of my thinking about how to: (i) adopt a critical stance during analysis (Fitzgerald, 2007); and (ii) devise and organise data extraction to interpret what the purpose and reasons for the document may have been (Shaw et al., 2004). Once I had developed a draft set of provisional questions from the above sources, I returned to all the documents and conducted the analysis (modifying questions as needed). This overall approach helped me to analyse each document systematically, develop codes, and prompt my thinking about what the implications and tensions of the initial findings might be.

Table 4.3 Questions for Documentary Analysis

Category	Question
Content	<ul style="list-style-type: none"> • What was the policy's stated aim? • What were the policy's main recommendations? • What information/evidence is provided to justify/support main recommendations? • Are specific measures of policy success stated? (If so, what are they?) • Is 'community engagement' specifically discussed? If so, how is it represented?
Actors	<ul style="list-style-type: none"> • What actors are meant to be involved? • How are these actors meant to be involved? • How is the role of ADPs represented? • What was the role of other local government entities (Community Planning Partnerships, Health and Social Care Partnerships, Health Boards, Licensing Boards) constructed to be? • What actors seem to be 'missing' or excluded?
Context	<ul style="list-style-type: none"> • How are different contexts conceptualised and discussed? • Is 'local context' or local needs specifically discussed? If so, how? • Does the policy link to or draw upon other policies/guidance from the broader policy landscape? If so, which ones, and in what ways?
Process	<ul style="list-style-type: none"> • Where does the policy locate responsibility for pursuing its recommendations and achieving its aims? • How is accountability characterised? (e.g. formally defined and outlined? Remains unstated or assumed?) (Is there a stated expectation for ADPs and local actors to use 'evidence' in their decision-making?) • How is monitoring and evaluation of the policy process or outcomes proposed to occur? • Is there explicit guidance for policy implementation contained within the policy? If so, • What would you expect to see implemented by ADPs based on the policy's content? • Is the level of autonomy of implementing stakeholders (i.e. ADPs) discussed? If so, how is it represented? • What are the expectations of ADPs in terms of 'community engagement'? • What is the proposed process for collecting, allocating, and distributing resources? • Are there observable tensions between <i>expectations</i> of local stakeholders contained within the policy and what may be feasible/observed in practice, judging by how the policy describes their roles, responsibilities, and resources?

While the documents were useful, for example in representing policy decisions made by Scottish Government, I reflect that they inevitably presented a limited account of the Government's implementation plans and expectations (Ritchie et al., 2013). Further, I was not able to interrogate each document (Schwartz-Shea and Yanow, 2012) beyond what was available in the text regarding the underlying mechanisms of how implementation of the alcohol strategy was subsequently

enacted (or alternatively, the countervailing mechanisms that were barriers to implementation). However, I was able to address these limitations by also employing interviews in this research.

4.5 Semi-Structured Interviews: Rationale and Approach

4.5.1 *Selecting Semi-Structured Interviews*

I selected interviews because it was critical to understand the perceptions of alcohol policy implementers about how they were undertaking the policy work of implementing Scotland's alcohol strategy. I perceived that rich, meaningful data could be generated through interacting directly with policy implementers, for the purposes of understanding and (re)constructing their experiences (Mason, 2002).

My selection of interviews was also predicated on my beliefs and understanding of how best to explain a social phenomenon like the implementation of an alcohol strategy. I view such explanations as requiring an emphasis on the influence of context, and on "depth, nuance, complexity and roundedness in data" (Mason, 2002, p. 65), as opposed to broad, but shallow understandings of the relevant phenomena. As a result, I wanted to use research methods which would be flexible enough to allow me to deeply explore relevant analytic themes I had pre-identified from the literature, while also generating others inductively from the data, all while maintaining the connection to context (an imperative for interpretive research) and an awareness of complexity. Qualitative interviews were well-suited to these purposes.

Following my interpretivist approach, I regarded my interviews as purposefully held conversations (Mason, 2002; Ritchie et al., 2013), in which knowledge is jointly constructed (Holstein and Gubrium, 1995; Smith and Elger, 2012) or "generated" by the interviewee and researcher (Ritchie et al., 2013). As a result of this, I do not represent data as a pre-existing entity that was 'collected' – instead I write about 'generating' data in the context of participating in interviews with participants (Braun and Clarke, 2013; Yanow and Schwartz-Shea, 2006).

To elaborate, I draw on Holstein and Gubrium (1995), who explain that, "both parties to the interview are necessarily and unavoidably *active*. Each is involved in

meaning-making work.” (p.4, emphasis in original). Conceptualising the interview as a purposeful conversation between two active participants seemed more useful than an approach adopting standardised questions. This is because the knowledge generated from interviews was contextual and situational (Mason, 2002). Thus, I approached my interviews as “meaning-making occasions” (Holstein and Gubrium, 1995, p. 4), in which I was an ‘active interviewer’, with the perspective that any resultant data would be interpretive and context-dependent.

4.5.2 Data Generation: Local Level Interviews

Access and Recruitment

In preparation for interviews in each local area, I reviewed the local ADP’s publicly available papers, strategies and annual reviews. Given that I did not know any of the potential interviewees in each local area (except for the ADP coordinators with whom I had been in previous contact), I recruited interviewees by first attaining the list of names and emails of the core ‘Executive’ from the ADP’s website or their administrator. I then emailed each individual directly. I sent a follow-up email after one week if I had no response, and emailed a third and final time if necessary, after which I categorised them as a non-responder (Table 4.4). The recruitment email briefly detailed the research project, stated my request for an interview, and outlined why I had chosen this individual as a potential interviewee. I also attached a two-page ‘Research Statement’ which provided further details about the project (Appendix 7).

In addition to the use of ADP membership lists I used ‘snowballing’ to identify additional potential interviewees (Miles et al., 2014). Snowballing was also helpful as a way of identifying when I was approaching the ‘saturation point’ of a given area, as interviewees began to recommend colleagues with whom I had already spoken. Although this overall recruitment approach generated a diverse set of local interviewees, one consequence was that some of the interviewees I recruited ended up having less useful knowledge given that they were less centrally involved in implementing the alcohol strategy.

I also recruited local interviewees from the LB in each area (see Chapter 2). Here, I followed a similar procedure to recruit LB members as I had with ADPs, accessing

the publicly available list of LB member names from local Council websites and contacting individual LB members directly to request an interview.

The responses to my local recruitment is summarised in Table 4.4. Where individuals declined, most gave the reason that they had recently left their post or were no longer involved with the ADP. The majority of individuals who were non-responders were LB members.

Table 4.4 Recruitment responses at local level

Response	LA1	LA2	LA3	Total
Agreed	17	16	21	54
Declined	5	1	3	9
No Response	4	5	7	16
Total	26	22	31	79

My experience recruiting participants was easier than anticipated. Most individuals were generous with their time, and seemed genuinely interested in participating. Reflecting on this, I perceived that gaining the approval of the ADP Executive prior to recruiting individuals was critical to this success, as it meant the individuals I was approaching were generally already familiar with the research and had already agreed for the ADP to participate. The relative lack of interest by LB members may have been a consequence of not seeking their collective approval through a similar 'gatekeeper' before recruiting individuals. In addition to these aspects of recruiting, this research may have had greater credibility and legitimacy because it was a) supported by the University of Edinburgh, a well-respected, Scottish university, and b) funded by What Works Scotland, an initiative funded by the Scottish Government. These affiliations may have contributed to the positive receptions I received from interviewees.

Interviewing took place from December 2015-January 2017. The majority of interviews took place during multi-day visits to each local area. Interviews ranged from 40 minutes to two hours in length. They were most often conducted in the person's office or a private room within their office building (with two exceptions, both at interviewees' requests: one in the person's home³⁵, and one in a restaurant).

³⁵ I decided it was permissible and safe to conduct this interview at the request of this interviewee who expressed that they needed to look after their granddaughter at the time of our interview (and did not express a willingness to alter the timing of the interview).

The length was partially dependent on the verbosity of the interviewee, but also on how much time the interviewee had to spend. The average interview lasted approximately one-and-a-half hours. In one case I conducted two interviews with one person because of the quantity of knowledge and central position of the person within the local system of alcohol policy implementation.

During my fieldwork I was conscious of how I presented myself in my interactions with interviewees (Schwartz-Shea and Yanow, 2012, p. 62). Within each interview, I was keenly aware that my Canadian accent identifies me as someone raised outside of Scotland, and thus an 'outsider'. I tried to take advantage of my outsider status to allow me to ask for clarification on what might be considered a well-known local policy process (Sabot, 1999). Otherwise, however, I sought to present myself as a trustworthy, competent 'insider' among the professionals I interviewed. Specifically, given the management positions of my interviewees, I dressed in a recognisably professional style for these interviews (in contrast to other interview experiences I have had, where more casual dress felt more appropriate). Table 4.5 below lists the final number of interviewees I spoke with in each local area, by their organisational affiliation.

Table 4.5 Number of interviewees from different organisational affiliations

Sector	Number of Interviewees by Local Area			Total
	LA1	LA2	LA3	
ADP-related interviewees				
ADP Role Only	2	2	3	7
Health Board	3	5 ^c	6	14
Fire & Rescue Service	N/A ^b	1	N/A	1
Education	0	0	1	1
Social Services ^a	3	4	2	9
Police Scotland	2	2	2 ^d	6
Prison Service	0	0	2	2
Local Councillor	1	0	0	1
Third Sector Representative	1	1	1	3
Licensing- related interviewees				
Licensing Board Member	4	1	3	8
Licensing Clerks	1	0	0	1
Licensing Standards Officer	0	0	1	1
Total	17	16	21	54

^a Includes those working in Adult Support and Protection, Criminal Justice, Mental Health Services, and Children and Families Services

^b Where N/A is written, no representatives from this sector were on the ADP or were suggested during snowballing

^c One interview with a health representative was conducted as a joint interview, where they invited a colleague from a neighbouring ADP to also participate in the interview

^d Both representatives spoken with during one joint interview, as per their request

Local Level Interview Format and Structure

Each interview was audio recorded, with interviewees' consent. Most interviewees seemed pleased to have the opportunity to speak with someone who was interested in their day-to-day work. I tried to encourage this enthusiasm by building rapport and trust between us and being transparent about the research aims (Harvey, 2011).

In the lead-up to my fieldwork, I initially assumed that I would be 'vulnerable' to my interviewees because I needed their cooperation for the success of my research project, but I also appreciated that my interviewer-interviewee relationships would probably be more complicated and dynamic than this. Exploring literature on 'elites' helped me to interrogate this relationship more deeply, including reflecting upon the positionality and 'situatedness' of my interviewees and myself in relation to one another. My early assumption was grounded in the perception that a power differential would exist between myself and the interviewees (Finlay, 2002), which would consistently be skewed in favour of them. Indeed, some of the literature on

interviewing 'elites' suggests that the authority of these 'elites' will be enacted within the interview setting. For example, Desmond (2004) argues that elite interviewee-interviewer relationships are always asymmetrical towards the interviewee (note that others have critiqued this claim (e.g. Smith, 2006), but I came to these critiques later). After engaging with methodological literature on interviewing 'elites' more broadly (e.g. Harvey, 2011, 2010; McDowell, 1998; Smith, 2006), I decided that I did not consider my interviewees to be elites because, while they do have decision-making responsibilities, they are influenced by the higher-level decisions of more senior individuals in local and national government – for example, in terms of the mandates and financial resources they are given. However, what I took from some of this literature was the importance of trying to reflect on power dynamics in interviews, for example by including relevant reflections in my interview notes after each interview.

Reflecting on the actual experience of fieldwork, I rarely perceived significant power imbalances to be playing out within the interview space. I perceived that I was consistently treated respectfully in interviews and it was only in a small minority of interviews where I perceived the interviewee wished to rush through the interview, signalling they wanted to give only limited time to the research. In these circumstances, I attempted to use the interview time efficiently, while being careful not to skip over necessary probing questions. Although I was prepared for interviewees to attempt to control or lead the conversation, having read about others' experiences of this (Harvey, 2010), this rarely happened. When interviewees were long-winded, I perceived this less about taking control, and more about them fully utilising the opportunity to 'vent' their information and experiences to me, a dedicated listener.

Further, many interviewees explicitly stated they perceived my research to be valuable, and expressed a desire to hear about the research results. Participants also seemed readily willing to put me in contact with other potentially relevant interviewees, which I interpreted as a marker of their interest. One national-level interviewee, however, following their interview and while helping me to exit their office, commented that perhaps I was focusing too much on the role of ADPs in my research. I considered this comment in light of all the local-level fieldwork I had already conducted, my engagement with different sources of data, and this person's

position as situated at national-level. I decided that, given my research aim and for reasons already discussed in Chapter 2, my focus on ADPs remained appropriate. However, I also recognised and accepted that the knowledge claims I could make would be inevitably limited to those surrounding the meaning-making of these particular individuals and groups (Schwartz-Shea and Yanow, 2012). Given the membership turnover within ADPs, this includes a recognition that my findings are also situated in the particular time period in which I was conducting my fieldwork.

In addition to considering the ways I could be vulnerable to my interviewees, through my engagement with methods literature I recognised the possibility that an interviewee could also feel vulnerable to me as the interviewer. My interpretation of the interview data, and my decisions about what data is included or excluded (in other words, what voices or perspectives are 'heard' and 'not heard'), would give me power in how the data was used (Harvey, 2010; McDowell, 1998).

Given this possibility, and that feelings of vulnerability on the part of the interviewee could make them feel less comfortable sharing information with me, I felt it was important to help them feel as comfortable as possible while participating in my research. I sought to do this by, for example, ensuring that I fully explained the anonymity and confidentiality that they as a research participant had in this research, that they have the freedom to withdraw from the research at any time, and conducting the interview where they felt most comfortable. I also offered to return to each ADP and present early interpretations of my findings. This offer was accepted in all three local areas, and I was able to use this opportunity to reflect on how my interpretations were received – this is discussed further in Section 4.6 on member-checking.

Local Level Interview Schedule

I used my initial, draft research questions as the starting point for developing an interview schedule, and supplemented this with key themes from relevant literatures. The schedule was discussed with my supervisors and modifications were made on the basis of framing and tone. I used this schedule in interviews with LA1, contextualising it to each interview (e.g. different questions for representatives of social work and police). I made more substantive adjustments for interviews with LB members, when it became apparent that interviewing this group was necessary for

understanding the licensing dimension of alcohol policy implementation, but that their role was very different from ADP members.

Following interviewing in LA1, I went through the schedule in detail, reflecting on the utility of each question, my perception of how understandable each question was for the participant, whether the question had yielded rich data, etc. This resulted in a modification to how I communicated with interviewees about their uses of evidence. I had originally split the schedule into two main sections: a) questions about alcohol policy implementation, and then b) questions about evidence use within alcohol policy implementation. On reflection, this was likely a function of my own research interests – my interest in evidence use within implementation made me want to emphasise it in my interviews, leading me to separate it out as a distinct topic. However, I found this structure slightly awkward when undertaking interviews in LA1 and felt I ended up spending more of the interview time on the first section, leaving the second section rushed. Further, I found that interviewees sometimes struggled to understand what it was specifically that I wished to know about their evidence use (e.g. sometimes asking for clarification). It seemed that I needed a more tangible, relatable way to ask about this topic. I therefore modified the schedule to integrate the two sections. This allowed me to ask interviewees about their work translating and implementing alcohol policy, and then to probe whether and how they used evidence in the context of this work – thus positioning these questions as deeper explorations of interviewees' implementation practices.

These changes reflected the balance I struck between wanting to ask specific questions of the participants without prompting them to speak about certain things (e.g. I didn't want to prompt them to mention certain aspects of context that they may think are important influences on their work). Further, I knew from engaging with evidence-use literature to avoid "assum[ing] that individuals are necessarily aware of the ways in which they come to learn about the findings from research." (Nutley et al., 2007, p. 65)

Upon reflection, this revised topic guide improved my access to the types of insights I sought to elicit regarding local implementers' perceptions and uses of evidence, and I maintained this structure for both LA2 and LA3 interviews. While the above changes represent some intentional flexibility to data generation which is a

characteristic of interpretive research (Schwartz-Shea and Yanow, 2012), a key limitation was that I did not have the opportunity to use the revised schedule with interviewees from LA1.

One aspect of the interview schedule related to evidence use which I retained, however, was a card exercise I conducted near the end of each interview. My use of cards to explore interviewees experiences of using evidence was adopted with similar intentions to using visual materials in qualitative research, for example graphic- or photo-elicitation (Crilly et al., 2006; Harper, 2002). Using cards followed the tradition of using visuals as 'stimulus materials' in interviews (in this case about barriers to evidence use) to elicit ideas or stimulate memory (Crilly et al., 2006). I was also hoping that it might enable interview conversations to build on, rather than simply repeat (or affirm) existing findings that have emerged with some consistency across studies regarding evidence use in policy and practice.

The cards drew directly from existing literature: on each card was a known barrier to using evidence in policy and practice (Oliver et al. 2014). Interviewees were asked whether any of the barriers resonated with their own experiences of trying to use evidence when implementing alcohol policy locally in Scotland, and about whether and how they had tried to overcome those barriers. Given that the exercise came near the end of each interview, I perceived it had benefits for (i) helping to make the interview additionally engaging for the interviewee, and (ii) for keeping our discussion succinct and focused in light of limited interview time remaining. Since my analysis suggested a focus on barriers was not the most useful way of understanding evidence use in the context of local alcohol policy implementation in Scotland, I have kept the account of this aspect of the interviews short - see Appendix 8 for more detail.

4.5.3 Data Generation: National Level Interviews

Following my documentary analysis and early analysis of local interview data, I sought to enrich and add clarity to my findings (which often referred to national level decisions, actions and assumptions) by generating data through interviews with national level stakeholders. In doing so, I consciously expanded my 'exposure' to interviewees with different positionalities from those at local level.

During early stages of my research planning I briefly considered doing national level focus groups. This was on the basis that focus groups could be a potentially 'efficient' way to help me access national level perspectives in order to 'test' or corroborate what had been reported to me at local level. Ultimately, however, I opted to use interviews. This decision was pragmatic and purposeful, and aligned with my overall interpretivist approach (and reflected the evolution of my learning about this approach). To elaborate, upon reflection this pursuit of 'efficiency' in developing a research design was pragmatically misguided given that focus groups presented logistical issues of getting multiple, busy stakeholders into a room at one time. Additionally, I came to appreciate that I was not seeking to 'test' or 'triangulate' the national level interview data with the local level data (Schwartz-Shea and Yanow, 2012), and that 'efficiency' was also not a primary goal. Instead, I sought a method which would present opportunities to access rich, situated accounts of individuals' perceptions, interpretations, and contextual expertise regarding the alcohol strategy at national level. I also perceived benefits in speaking with each person individually, to allow each national interviewee to feel comfortable critiquing the strategy if they wished. I felt this was more likely in a one-to-one interview than in a focus group with interviewees' colleagues.

I recruited interviewees who currently were, or had previously been, involved in the development and delivery of alcohol policy and/or legislation in Scotland. This included a range of representations across public and third sector organisations. Using a similar approach to that which I had used when recruiting local level interviewees, I emailed each potential interviewee directly with a tailored email, and sent follow-up emails as necessary. The recruitment responses are summarised in Table 4.6 below. Given that I undertook this recruitment almost entirely towards the end of data generation, I had had two years of embedding myself into the Scottish alcohol policy arena. Therefore, unlike my local interviews, I had often already met, spoken with, or even briefly discussed my research with, many of the people I contacted for interviews, and suspect that this assisted national-level recruitment significantly.

Table 4.6 Recruitment responses at national level

Response	Number
Accepted	9
Declined	1
No Response	1
Total	11

One pilot national level interview was conducted at the beginning of this research project as interview practice and to test the initial interview schedule, however the rest were conducted following local level interviews. I used a modified version of my interview schedule for these interviews, and used the same audio recording device and ethical procedures (Section 4.8) as for the local interviews.

4.5.4 Thematic Analysis of Interviews

All audio recordings of interviews were transcribed verbatim into individual Word Documents, either by myself or by a professional transcription company (who had confidentiality agreements in place with any staff who had access to the recordings). I originally intended to transcribe all interviews myself, but time constraints necessitated that I outsource transcription of some interviews. For interviews which I had professionally transcribed, I went through each audio recording with the transcription to double-check the company's work. Because I initially chose a company based in America for financial reasons, often their unfamiliarity with Scottish accents resulted in minor mistakes, which I then corrected. This process also led me to re-listen to each interview, again ascertaining the tone and other verbal cues of the participant which I could consider in my analysis. However, the American company was unable to understand accents from interviewees in my most rural Local Area so I changed to a Scottish company for the final round of transcription. Confident in their transcription, I would not re-listen to each entire interview, only re-listening to certain sections where I wanted to check the transcription. While I offered interviewees the chance to read their interview transcripts (but did not offer for them to edit the transcript, e.g. to rephrase their responses), most declined. Of those to whom I did send their transcript, none responded with any questions or feedback.

I analysed the interviews thematically, following researchers such as (Braun and Clarke, 2013, 2006; Clarke and Braun, 2018; Mason, 2002). Advantages of thematic

analysis include its flexibility; its accessibility to researchers who have limited previous experience in qualitative analysis, and its usefulness in helping a researcher to synthesise detailed information from a large data corpus while still retaining richness and complexity (Braun et al., 2015; Braun and Clarke, 2006). Risks of this approach, however, are that the researcher limits themselves to only describing the data, provide insufficient evidence to support their ideas or arguments, or are not sufficiently transparent in explaining how they undertook their analysis (Bazeley, 2013; Braun and Clarke, 2006).

To undertake my analysis, I first read each interview transcript, during which I constructed an idea of what I could construe from the data (Mason, 2002). Practically, I organised the data by coding transcripts in NVivo 11 qualitative data software (QSR International Pty Ltd, 2010). To give myself a flexible organisational structure to work within, I initially used provisional, a priori codes, which allowed me to maintain an openness to the emergence/generation of other themes. I generated these initial codes based on my pre-existing understanding of potentially important topics, informed by the findings of my iterative engagement with literature, my research questions, and my recollections of the interviews themselves. These codes included, for example: 'local relevance of Strategy', 'prioritisation of Strategy actions', and 'sources of evidence'.

I then undertook a more in-depth, iterative process of generating codes from the data. Following common practices for thematic qualitative analysis (Bradley et al., 2007; Miles et al., 2014), this involved creating new codes where needed, and further developing, expanding, or adapting my existing codes. My analysis thus represented a combination and synthesis of concepts, interests, and ideas which had been identified a priori and which were generated from the data.

My approach to analysis as described above was necessarily an interactive one between my research questions and data (Mason, 2002). To facilitate this throughout the analysis, I made annotations in the transcripts themselves with my initial reflections/analyses, and wrote memos in NVivo with reflections about individual interviews and key themes or ideas. This process of supplementing the data with additional notes was helpful for moving from mostly descriptive coding to develop more analytical codes, particularly as I began drawing from across the data

corpus to develop my ideas. While I carried out my formal analysis of documents after I had already been coding my interviews for a few months, my interpretations of the interview data will have invariably been influenced by my previous reading of, and discussions about, relevant documents. Further, the influences of the two sources of data on my thinking will have been intertwined during writing up my findings.

Having engaged with certain practical qualitative methods literature (e.g. Bazeley, 2013; Miles et al., 2014; Saldana, 2016), I appreciated that the coding and analysis process would be complex and iterative. I believed, however, that with sufficient effort I could 'organise' my analysis enough to manage this complexity – i.e. that I could develop well-organised, systematised coding trees which would neatly capture my analysis (a belief possibly borne out of my personality, which consistently seeks to organise when presented with chaos). However, I was quickly disabused of this as I dug deeper into my analysis, and the number of codes, and the connections I interpreted between them proliferated. Further, I realised I needed to move beyond this idea of trying to over-control the coding and analytic process, and allow interpretation and patterns to be generated more organically (Schwartz-Shea and Yanow, 2012). Consequently, as I sought to make this transition and evolve in my thinking from descriptive to more analytic, I found two exercises particularly useful: (i) developing a series of relatively short, thematic pieces of draft writing (akin to a 'vignette'), which each explored a particular overarching theme or concept and helped me to begin to make sense of the messiness of the initial codes I had developed; and (ii) visually mapping the key concepts and themes I had generated (Bazeley, 2013; Braun et al., 2015), drawing organising concepts, their related themes, and the connections between them.

During the process of analysis, I found it particularly useful to go back to the data repeatedly (as suggested in the literature, e.g. Braun and Clarke, 2006) to observe or think more about where themes and codes tended to overlap in my coding (i.e. where I had frequently double-coded using the same sets of codes). From this, key observations emerged, for example the importance of partnership working contexts in helping to explain ADP members' experiences of accountability (developed in Chapter 5). I was also interested to find that the longer, narrative stories interviewees told during interviews were rich sources of insight, often covering

multiple codes/themes (Bazeley, 2013). This was particularly the case once I revised my interview schedule and began asking interviewees to speak in-depth about particular alcohol policy activities in which they had been involved in implementing – a revision which better reflected my interpretivist and policy practice perspective, specifically recognising the importance of actors negotiating practice through stories (Bevir and Rhodes, 2012).

I also sought to check were there were inconsistencies, tensions, or potential “silences in the data” (Schwartz-Shea and Yanow, 2012, p. 105). For example, in Chapter 5 I discuss ADP member experiences of different types of accountability, and a surprise in this analysis was how little the ADP members discussed their accountability to their local governance hierarchy (specifically Community Planning Partnerships) compared with the detail they used to discuss perceptions of accountability to the Scottish Government. However, this could have been a consequence of how we were co-generating this data, in terms of the interviewees responding to what they perceived I was most interested in (i.e. the national alcohol strategy, and thus the relationship of ADPs to national level government), despite me asking about their perspectives on Community Planning Partnerships in interviews.

When writing the results chapters, as I discussed a particular theme or concept I felt was reflective of the data overall, I selected quotations I perceived to effectively represent or illustrate the theme. In each instance, however, I sought to check these points across the different sources, and aimed to reflect on the extent to which there was (or was not) consistency of an expressed perspective or view across different sources. I aimed to comment on this in the results, for example noting within the analysis where a particular quotation was selected to demonstrate a contrasting or minority perspective.

4.6 Member-Checking

I considered two methods of checking my sense-making within my analysis: requesting the assistance of a relevant colleague to check a minority of the results (Bazeley, 2009) and member-checking (Schwartz-Shea and Yanow, 2012). Regarding the former, and reflecting on my philosophical approach, I decided that

asking a single colleague to 'check' my results would introduce an assumption they were checking whether I reached the 'right' explanations (and that they would know what the 'right' explanations were). Instead, I felt conversations with my supervisors, peers, during conference presentations, and with stakeholders such as AFS provided additional space to discuss and reflect on my initial interpretations.

In the end, I focused on member-checking my analysis with my three participating local areas. During the analysis phase of this research I asked my participants to comment on my early findings (Miles et al., 2014). During 2016-2017 I attended an ADP meeting in each local area following analysis of that area's interviews, and presented emerging findings to the group for their reflections and feedback. I used this member-checking approach to check the accuracy and fairness of my interpretations and representations of the data, with the intention of increasing the credibility of the analysis (Simons, 2009). Additionally, this also served a knowledge exchange purpose, as I was able to communicate my early interpretations and findings to the participating areas.

I found that these sessions had limited usefulness for my analytic work because the feedback was light-touch and almost unanimously positive. I did not receive much constructive criticism, in that the interviewees did not tell me whether my findings contradicted what they had intended to communicate in their interviews. This could have resulted from a number of factors. For example, I may not have presented sufficient detail of my findings for the audiences to critique; they may not have perceived the findings to be in contrast with how they had tried to portray their experiences; or they may not have felt comfortable challenging my conclusions. Considering the latter, I did encourage individuals to contact me privately with further feedback if they wanted to but none did. Further, because the member-checking sessions happened a few months after my fieldwork in each area there were often new ADP members in attendance, some people were hearing about the research for the first time, and perhaps did not feel in a position to offer in-depth critique.

I did not conduct member-checking with national level interviewees. However, by making a presentation to AFS midway through my analysis, I was able to receive feedback about my emerging findings from the key advocacy organisation focusing

on alcohol policy in Scotland³⁶. This also helped me to keep up to date with any policy changes occurring after my fieldwork.

4.7 Contextual Observations

To inform my research, between 2015-2017 I observed 16 meetings and events, both within the local areas and at national level. This included six ADP Executive team meetings, three LB meetings, and multiple AFS 'Knowledge Exchange' events. While these observations did not constitute a formal source of data, they provided me with access to critical contextual information about, and familiarisation with, the broader priorities, successes, and challenges surrounding the Scottish alcohol policy landscape (Braun and Clarke, 2013; Ritchie et al., 2013). They also provided an opportunity to gain an understanding of tacit knowledge held by participants, observing them enacting work and interactions that were perhaps less 'articulable' during our interviews. All of this assisted my thinking when analysing the interviews and documentary sources. For a full list of meetings/events observed, see Appendix 9.

4.8 Ethical Considerations

4.8.1 Ethical Approval

This PhD research was granted Level 2³⁷ ethical approval by the School of Social and Political Science of the University of Edinburgh in April 2015 (Appendix 10). Although the research itself was considered low risk, in consultation with my research supervisors, I applied for and was granted Level 2 approval because I knew that one potential interview participant had a physical health issue that could cause them discomfort and adverse effects during our interview. For the ethics application, this risk was addressed by stating the measures I would take to check and safeguard the participant's wellbeing during the interview, including meeting with them at a time and in a location that was most convenient and comfortable for them.

³⁶ Additionally, Alison Douglas, CEO of AFS, read and commented on Chapter 2 of this thesis.

³⁷ At the time I sought ethical approval, the School's approach was to have three levels of approval: Level 1 – low risk; Level 2 – some risks with clear plans to manage; and Level 3 – higher risk or complex projects that require discussion.

I also sought ethical approval from the relevant authority for each participating local area prior to fieldwork in that area. In each case, the 'relevant authority' was named by my key contact in the ADP. For LA1, ethical approval was attained from the Council. For the LA2 and LA3, ethical approval was attained from the local NHS Health Board, each with a slightly different process. All (anonymised) ethics approval paperwork can be found in Appendix 11.

4.8.2 *Interview Ethics*

A Participant Information Sheet that included information about the research, researcher, and funding for the project was developed and given to each participant prior to the interview, in line with established research practice (Wiles et al., 2005). An Informed Consent form was also developed, and was signed by each participant. I made a minor, non-substantive revision to the consent form following the first Local Authority interviews, to improve its clarity for interviewees³⁸. In discussion with my supervisors, this minor edit was agreed to be covered by the ethics approval already in place for the research. I continued to give participants the opportunity to opt out of confirming any (or all) of the specific statements of consent (for example, it was possible for interviewees to opt of the interview being audio recorded, while still consenting to the interview and subsequent analysis). However, none of the participants declined to consent to any statement. No other changes to the forms were made during the course of the research. See Appendix 12 for the original and revised forms.

Given that I did not formally collect data from my observations of meetings, and did not directly use or quote any discussions at these meetings, I did not deem it necessary to seek informed consent from attendees at these meetings. However, at each ADP meeting I introduced myself and my purpose for attending, making clear that I would not be identifying any attendees, and encouraged attendees to contact me with any questions or concerns they had about the research (no one did).

³⁸ I had originally asked participants to tick 'yes' or 'no' in response to the statements on the consent form (e.g. whether they agree to take part in the study, etc.). I revised the form by removing the 'no' boxes, because my early interviewees expressed confusion and asked me why the 'no' box was there. Thus, the revised form asked participants to tick 'yes' to confirm their agreement to each statement on the consent form.

4.8.3 *Enacting Ethical Research*

Although the institutional ethical applications were relatively straightforward, the process of enacting ethical research practice throughout the data generation and analysis process was a more challenging experience because I had promised anonymity to participants. My reasons for promising this were multiple, including wanting to create an interview environment in which participants felt comfortable to provide candid and open answers, rather than feeling constrained by how material might be attributed to them (Miles and Huberman, 1994). The commitment was also made to protect participants, in the event that they said something in the context of an interview that could harm their interests, position, or career if it were to become public (Miles and Huberman, 1994). For example, I wanted interviewees to feel free to be critical of their ADP, Local Council, the Scottish Government, or other stakeholders in alcohol policy, and protect against any harm that could result from criticism communicated in the course of their research participation.

In light of this, I made the decision to keep both the identities of individual research participants and the local areas confidential. I realised that the small number of people working on alcohol policy implementation in a given local area (typically 15-20) meant that if the local areas were identified then the individuals may also be identifiable. This would be even more likely because I planned to identify participants' organisational affiliations (e.g. Police, Social Work, Prisons, ADP Administration, etc.) if I needed to provide greater context about their perspective when quoting them. Given that there are often only one or two participants on a given ADP from each organisation, they would have been identifiable if the local areas had been named.

Additionally, there was explicit concern expressed by some participants (albeit a minority) about ensuring their confidentiality was preserved. For example, with respect to their job security one participant stated:

Interviewee: Is it ok if I tell you things and say "Can you anonymise that"?

AW: Absolutely

Interviewee: That would be good, because if I'm critical of the Council publicly, then I could get in trouble...I'd like to be as

honest and up front as I can without looking like I'm gonna get myself sacked.

Maintaining this double layer of confidentiality often proved challenging, though ultimately manageable. This largely reflected three factors: 1) the interest of colleagues and stakeholders about which local areas I was working with, 2) the level of context-specificity of activities and policy environment of each local area, and 3) the relaxed nature of certain participants about whether they were identifiable to their immediate colleagues. For example, national-level stakeholders sometimes asked which local areas I worked with, and often colleagues at conferences or other settings asked whether I was working with a given area they were already familiar with. In each instance, however, I simply explained that the confidentiality arrangements in place did not permit me to divulge this, and this was consistently accepted. Additionally, during each interview, I asked each participant to keep their participation in the research confidential when speaking with people outside their own ADP (though, of course, could not in any way control whether they actually chose to speak about it or not). I remain aware that, although I felt I took all possible steps to prevent the identification of local areas and individuals in the research, a 'knowledgeable insider' may still be able to piece together enough information to feel that they know where a particular area is or even, perhaps, who a particular speaker is (Crow and Wiles, 2008).

One aspect of the above challenge was that, when recruiting participants, I would sometimes be asked by a potential interviewee whether I was interviewing a particular colleague, as they thought it would be convenient to be interviewed together. There were two instances in which colleagues conferred with each other while I was recruiting them both, and requested to be interviewed together, in what the literature calls a 'dyadic interview' (Morgan et al., 2013). I decided to accept this request and interviewed them together, after considering potential risks to the participants. For example, I decided this would not be problematic ethically because both interviewees were informed by me to keep their local area confidential, however this could have presented a problem if one declined to be interviewed but knew the other was going to participate. For this type of situation, however, I had to be aware that participants were free to tell their colleagues within the ADP that they had participated if they wished.

4.9 Limitations of Methodological Approach

As with any research, my PhD research design was constrained by temporal and material resources. For example, I only had a finite time period in which to conduct my fieldwork, meaning I needed to select a limited number of local areas in Scotland to include in my study. Further, I needed to select local areas in Scotland which were feasible and affordable for me to travel to. A consequence of these constraints was excluding local areas which may have contributed new knowledge and insight into how Scotland's alcohol strategy was being implemented. As such, I do not claim that the findings of this research are 'generalizable'. However, while generalizability is often viewed as a highly valued standard of research, from my interpretivist standpoint I was more focused on generating knowledge that was contextualised (e.g. see my decision to use approaches which would help me to generate 'thick descriptions' of the chosen case which would enhance my understanding of the 'whys' and 'hows' of the Scottish alcohol strategy's implementation) (Schwartz-Shea and Yanow, 2012, p. 48).

Beyond this, I was conscious that I only met with most of my local interviewees once (despite member-checking and observing meetings). This means there were potentially missed opportunities to observe some of the dynamic meaning-making that my interviewees were undertaking over time, and to use more of my own learning to inform later, follow-up discussions or interviews (Schwartz-Shea and Yanow, 2012). As will be discussed in Chapters 5-7, this meant that I was unable to generate further data regarding my interviewees' ongoing experiences of certain contextual changes related to, for example, funding or legislation. However, because I did my fieldwork in each local area sequentially, I was still able to bring my learning from each area to my fieldwork in the next one (and into my later national-level interviews). Additionally, my contextual observations (Section 4.7) may have helped to mitigate this, particularly when I visited a local area a few months after my interview fieldwork, and observed their discussion priorities.

As a second example, the timing of my research also presented certain constraints on my design and analysis. I designed and undertook this research a few years after key policy and legislative decisions had been made (e.g. the *Framework for Action* was published in 2009 and the *Licensing Act 2005* was enacted fully in 2009). While I was able to analyse documents which helped to represent certain decisions from

that time, I was not able to access interviewee perspectives which could reflect on either the strategy's development or initial implementation as it occurred – the data generated in interviews was necessarily historical and influenced by interviewees' experiences since that time. My research is therefore specifically situated in a time in which the strategy had been already established for a significant time (and was therefore not a 'shiny' new thing, particularly given most of it appeared to be overshadowed by the energy and resources required to support the MUP court case), and a 'refresh' was already being discussed. Potential benefits of this, however, were I had the opportunity to investigate the 'everyday' work of local implementers who (i) had to continue implementing the strategy long after many of its components were no longer in the national political or media limelight, and (ii) could reflect upon their experiences (e.g. challenges, successes) which, given the nature of the scale of changes pursued through the strategy, were only available after a substantive period of time had passed - this latter benefit being an observation previously made in the policy implementation literature (Sabatier, 1986). Additionally, asking stakeholders to reflect upon their experiences since 2009, with a view to thinking about informing the strategy 'refresh' was sometimes a useful 'hook' in interviews.

Third, I engaged with the selected case, fieldwork spaces, interviewees and documents as an external researcher – I did not 'participate' in these spaces or with these artefacts as an embedded researcher helping to carry out the work of implementing the alcohol strategy. I therefore did not have access to the opportunities that this type of participation would bring for accessing, observing or developing the tacit or embodied knowledge that being a local implementer of Scotland's alcohol strategy may have presented. I reflect here that while these types of embedded or ethnographic approaches could have been plausible alternatives to the approach I enacted, I did not consider using them when I was developing my research design. This may have reflected the assumptions I brought to this research (e.g. from my experiences at WHO and other professional positions), and my presuppositions which were informed by my initial engagement with the relevant literature and texts (Schwartz-Shea and Yanow, 2012). The combination of these may have contributed to my decision that it was important to use the time and resources I had available to engage with (i) interviewees at multiple levels of governance, and (ii) local interviewees from multiple areas.

Fourth, more specific aspects of my research design presented limitations. For example, my decision to exclude local ADP delivery strategies from my formal analysis means I am unable to discuss those sources of formalised/official, collective representations of how each ADP made sense of the national alcohol strategy, within their own contexts. However, this decision was made in order to maintain the anonymity of each local area, a crucial part of my agreement with each area when I was negotiating access to them. Further, I perceived that I could incorporate questions into my interviews which would help me to understand what had been included in each area's local strategy (having read them in advance to interviews), thus still generating contextual (but partial) knowledge about the content and decisions represented in the documents without directly reporting on them.

Finally, my interviewee data included a smaller number of LB members than ADP members due to the lower response rates. This may mean that my insights into LB practices were more limited than my insights into ADPs'. However, I reflect that many of the interviewees based within ADPs had good knowledge of LBs and much to say about LB practices. Further, there is more published research in Scotland focusing on licensing and LBs, so I was also able to draw insights from this research analysed in Chapter 3 (systematic review).

4.10 Conclusion

This research is underpinned by an interpretivist position, and conceptualises alcohol policy implementation as policy 'practice' or 'work'. A qualitative, embedded case study approach was employed, given its capacity to generate rich, in-depth descriptions and explanations of how Scotland's alcohol strategy was being implemented in three local areas, and the suitability of this approach to the study aim and research questions. In this thesis, the 'case' of interest was the implementation of Scotland's 2009 alcohol strategy, and the 'sub-units' of analysis were three, purposely selected local areas in Scotland.

The chapter described how I generated data through semi-structured interviews (at both local [n=54] and national level [n=9]) and documentary analysis (focusing on 16 national-level policy documents, which were a mixture of policies, legislation, and

guidance). The chapter also described my approach to data analysis, which involved taking inspiration from Walt and Gilson's Triangle Framework to help develop an approach to analysing the documentary data, while using thematic codes (generated a priori and through engagement with the data) to help analyse the semi-structured interviews.

In addition, this chapter provided a reflexive account of how and why I came to undertake this research. This included reflexive writing on my position as the researcher undertaking this work, and how my personal and professional backgrounds will have influenced how I approached the research. In particular, I noted that I felt my experiences in institutions such as WHO shaped the lens through which I initially viewed the problem of understanding and explaining the implementation of Scotland's alcohol policy (and the ways I sought to access information about this). As I explain, this changed as I progressed through my research and gained more insight into the expertise of local implementers.

Preface to Results Chapters

This thesis now turns to the results of my empirical analysis. To make this transition, in this Preface I explain the development of my research questions and the focus of my empirical analysis, which will be presented in the following three chapters.

As Chapter 1 outlines, the thesis is guided by an overarching research aim of investigating whether and how factors known to shape alcohol policy implementation in high-income settings shaped the local level implementation of Scotland's 2009 alcohol strategy. My research questions are:

1. How was local implementation of Scotland's 2009 alcohol strategy influenced by formal and informal accountability mechanisms in the contexts of:
 - a. Alcohol and Drug Partnerships?; and
 - b. Licensing Boards?
2. What roles (if any) did evidence appear to play in the implementation of Scotland's 2009 alcohol strategy?

As would be expected from an interpretive, qualitative research project (Ritchie et al., 2013) (see Chapter 4), the finalisation of these research questions (from draft form at the beginning of the project) was informed by an iterative interaction with relevant literature, preliminary assessment of my data, and reflections on my discussions with, and observations of, relevant stakeholders.

To detail each, the systematic review (Chapter 3) was developed in response to my research aim, and built on my earlier engagement with alcohol policy literature and initial data analysis. The systematic review identified three themes as being important for alcohol policy implementation: accountability and governance, evidence use, and context and resources. The first two directly informed my research questions – the results of the systematic review suggested there were important knowledge gaps in relation to 'accountability and governance' and 'evidence use' that could be usefully explored empirically, via my embedded case study. Regarding the third theme, the systematic review suggested 'context and resources' were important considerations for alcohol policy implementation research, but that (a) there were fewer obvious gaps to address (since most research identified context and resources as important for alcohol policy implementation in some way), and (b) issues around this theme seemed

consistently intertwined with other aspects of implementation. Therefore, I felt this theme might be more usefully presented as a cross-cutting theme.

In line with my interpretivist approach, my final research questions were also informed by my data and analysis. My preliminary data analysis suggested that, within the broader accountability and governance theme identified in the systematic review, it was accountability specifically that seems to be crucial to understanding and explaining the experiences of ADP and LB members in implementing Scotland's national alcohol strategy. Further, my original interest in evidence use, which had been incorporated into my interview schedule, did indeed appear to be an interesting and important topic in the context of ADP and LB implementation work.

Regarding context, I had incorporated careful consideration of this in my research design and analysis. My interpretive, qualitative case study approach (Chapter 4) explicitly sought to assess how variations in local context across Scotland might be shaping local implementation. For example, I had selected three different geographical contexts as my sub-units of analysis, and, in interviews, had asked about economic and political contexts. However, my data analysis did not identify obvious differences between the three local areas. Instead, it suggested the most interesting and important aspects of how context influences Scottish alcohol policy implementation was through experiences shared across the local areas (e.g. partnership working and constrained resources). In relation to resources, I paid particular attention to this issue in my data analysis and observations of local meetings. In interviews, I asked participants about resources, and gave them space to discuss different types (e.g. funding, human resources, technological support, etc.). My data suggested that funding in particular was a key, consistent concern among my interviewees but interviewees' accounts of the significance of resources were generally intertwined with their accounts of accountability and evidence use.

In light of the above, I decided that the final research questions should principally focus on accountability and on evidence use, whereas context and resources would be explored and discussed as a cross-cutting theme. The following three empirical chapters address my research questions in turn, with the Discussion section of each chapter also engaging with key issues relating to context and resources that emerge in the respective chapters. Question 1a is addressed in Chapters 5, Question 1b in

Chapter 6, and Question 2 in Chapter 7. Following this, the thesis Discussion (Chapter 8) considers the findings collectively and in the context of existing scholarship.

5 Confusion, Complexity and Miscommunication: Accountability in Alcohol and Drug Partnerships

5.1 Introduction

The purpose of this chapter is to examine how the implementation of Scotland's alcohol strategy was influenced by the operationalisation of accountability relationships in ADPs. Specifically, in this chapter I seek to map and analyse the different accountability relationships experienced by ADPs and their members, and to understand how these were influencing ADPs' implementation work. In light of this, this chapter addresses the research question: "How was local implementation of Scotland's 2009 alcohol strategy influenced by formal and informal accountability mechanisms in the context of Alcohol and Drug Partnerships?" This chapter builds on the systematic review (Chapter 3). The review found that, while multiple studies identified issues relating to governance and accountability as important for implementation, only one study (Fitzgerald et al., 2018) explicitly focused on accountability in Scottish alcohol policy implementation, suggesting a potentially important research need. As briefly highlighted in Chapter 3, this empirical work also builds upon those authors' work. Where Fitzgerald and colleagues provided an initial exploration of accountability-related issues identified by public health practitioners, their study did not focus specifically on examining the accountability systems of ADPs or LBs. Further, they restricted their study to interviewing public health practitioners (n=13) across 20 jurisdictions in Scotland about their perspectives on alcohol licensing, and did not include LB members.

The issue of local partnerships for alcohol policy implementation is important for this research because in Scotland individuals representing various organisations are brought together in ADPs to implement alcohol policy (Chapter 2). This possibly creates a tension between 'individual accountability' to one's organisation, and 'collective' accountability to the partnership. Additionally, the work of ADPs to implement alcohol policy is embedded in a broader policy context characterised by an enthusiasm for partnership working (e.g. Christie, 2011). This suggests that any analyses of accountability in Scottish alcohol policy implementation need to consider the potential influences of this partnership working context. Further, for research on

local alcohol partnerships to not yet have engaged with literature on accountability in partnership contexts is a missed opportunity (see Chapter 3).

To my knowledge, this is the first empirical study to map and analyse the accountabilities of ADPs in Scotland and to assess how these accountabilities influence their implementation work. My analysis of the data - national and local interviews and national documents - will suggest that the current configuration of ADPs' accountability regime is complex and presents potential challenges for ADPs' work implementing Scotland's alcohol strategy. Importantly, my analysis suggests that this regime is constituted of distinct accountability relationships between ADPs and other implementation stakeholders, and these can come into tension.

In the rest of this introduction, I will engage with relevant accountability literature, and then explain an accountability typology from Hupe and Hill (2007) which (organisationally) aided the analysis in this chapter. The results are then structured as follows. First, data regarding national expectations of ADPs' roles will be presented, as written in policy documents and reported by interviewees working at the Scottish national level. This is important because it provides a reference point for how ADPs were expected by national-level decision-makers to undertake alcohol policy implementation, and therefore what ADPs were to be held accountable for (from a national perspective). Second, data are presented regarding ADP members' perspectives on different types of accountabilities – and the different directions of accountability to diverse actors – that they experienced in practice. In particular, ADP members report varied experiences in terms of (i) accountability to the Scottish Government, labelled here as 'top down' accountability; (ii) accountability to partners in the ADP (or 'horizontal' accountability); and (iii) accountability to the public and service users ('bottom-up'). Reflecting this, the chapter discussion suggests a revision to the Hupe and Hill (2007) typology to better capture the complex and ambiguous accountability regime in which ADPs operate. It then situates the findings in relevant literature, presents plausible explanations for the findings, and discusses implications for how Scottish alcohol policy implementation occurs.

5.1.1 Using Accountability to Analyse Alcohol Policy Implementation

Accountability is a central concept within studies of governance (Bevir, 2009; Callahan, 2006; Dubnick and Frederickson, 2011). In this study of alcohol policy implementation, the concept of accountability is important because it helps explain how, when, and why key actors are responsible for undertaking implementation. The component parts of accountability processes—who is held responsible for policy implementation, how their actions are measured and judged, and how consequences are distributed—also provide insight into how governments perceive a given policy problem and its potential solutions. Following my findings in the systematic review (Chapter 3), it is useful to analyse Scottish alcohol policy implementation using accountability because, analytically, it can help a researcher understand and explain how implementation has been challenged or facilitated. The next few paragraphs explain my conceptualisation of accountability in this thesis.

First, because there was no clear or consistent definition of accountability in the studies from my systematic review, I adopted Bovens' definition: "a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences" (Bovens, 2007, p. 450). This definition captures three key phases of accountability (Schillemans, 2013), and offers a clear set of criteria against which an analysis of accountability in alcohol policy implementation could be effectively conducted. Within this definition, the 'actor' can be an individual or an organisation, and, similarly, the 'forum' can be an individual (e.g. a Minister) or an agency (e.g. a parliament, court, or inspectorate) (Bovens, 2007). The 'obligation' of the actor may be formal or informal (discussed further below). The sum of all an actor's accountability relationships constitutes their 'accountability regime' (Bovens et al., 2008, p. 225). I use Bovens' definition in order to help me assess and interpret whether relationships between ADPs or LBs (Chapter 6) and other alcohol policy stakeholders are indeed comprising accountability relationships.

Second, in this thesis I conceptualise accountability relationships as both formal and informal (Bovens et al., 2014b; Romzek, 2011). These different types emerged as relevant for my analysis, because evidence of both formal and informal accountability relationships were reported by ADP interviewees. The 'obligation' of the actor in the definition provided above may be a formal responsibility, such as the

requirement to submit reports on a regular basis to a forum. Alternatively, a more informal, self-imposed obligation which may arise from beliefs and norms among the relevant actors about how best to enact and govern relationships between themselves and other stakeholders (Dubnick and Frederickson, 2011). Formal accountability is the most commonly discussed in the literature, and is based on formal agreements, often structured by contracts about the roles, responsibilities, and expectations of the relevant stakeholders (Romzek, 2011). However, (Romzek, 2011) notes that “informal and norm-based accountability can be a significant complement to formal accountability relationships...[they] are at least as important to effective network operations as formal accountability structures” (p. 32). Informal types of accountability seem to emerge from: partners’/collaborators’ recognition of their interdependencies; a shared desire to work together; development of reciprocal relationships; and a sense of partner accountability which is characterised by shared norms and an informal system of rewards and sanctions (Romzek, 2011; Romzek et al., 2013, 2012).

Third, I conceptualise accountability as a ‘mechanism’ or an institutional arrangement, as opposed to a ‘virtue’ or a normative concept relating to the behaviour of individual actors. Accountability as a mechanism “involves an obligation to explain and justify conduct” (Schillemans and Bovens, 2011, p. 5). It is also aligned with the definition of accountability identified above, and can apply to both formal and informal types. From the ‘mechanism’ perspective, there is less focus on the behaviour of actors, and more on the institutional arrangements which *govern* their behaviour (Bovens et al., 2014b). Examples of accountability mechanisms may include system-level mechanisms such as elections, or administrative-type mechanisms such as auditing or performance reporting (Bovens et al., 2014b). Institutional accountability mechanisms may also be employed, such as independent regulators or audit institutions. Mechanisms such as performance targets are a way for central governments to control or govern the work of policy implementers, for example when the centre is trying to retain control over implementation processes despite broader shifts in governance to bottom-up approaches (Richards and Smith, 2004, as cited in Cairney [2012], p. 351). As was discussed in the systematic review (Chapter 3), performance measurement is relevant in UK alcohol policy contexts, in which targets and indicators are regularly used by governments. Informal or ‘intrinsic’ mechanisms also exist, such as

fostering certain norms which promise increased integrity, legitimacy, or fairness in governance processes (Dubnick and Frederickson, 2011). Viewing accountability as a mechanism is consistent with this project's concern to examine the operation of institutional accountability arrangements which help govern the implementation of Scotland's 2009 alcohol strategy.

Finally, actors may be held accountable 'collectively' or 'individually' (Bovens, 2007; Bovens et al., 2014). In the former, any actor in an organisation may be called upon to render account, regardless of their involvement in an action/decision (Bovens, Schillemans, et al., 2014). In the latter, individual actors are held to account only for their involvement in an action undertaken by the organisation (Bovens, 2007). Accountability within partnership-working contexts can be challenging because they include complex, potentially diverse and sometimes conflicting expectations (both among the actors within the partnership being held to account, and among the range of other stakeholders outside the partnership who are holding them to account) (Romzek, 2014; Steets, 2010). This is particularly relevant in the Scottish alcohol policy implementation context in relation to ADPs. As Thomas (2012) notes, shifts to more collective approaches to accountability require mechanisms which can account for collaborative arrangements.

Conceiving of accountability in the manner described shaped my empirical analysis. It ensured I consistently analysed accountability regimes of ADPs and LBs in terms of relationships across stakeholders. Further, it ensured I was open to the possibility for both formal and informal types of accountability to be identifiable within the findings.

5.1.2 Organising the Accountability Results: Hupe and Hill's (2007) Typology

In order to help make sense of the diverse ways in which accountability was discussed by my interviewees, I employed and critically engaged with a typology developed by Hupe and Hill (2007) as an organisational tool. This typology was initially attractive because it appeared to fit well with what I was learning from engaging in the policy implementation literature in the early stages of my research. Further, the selected typology treated accountability as a mechanism, but did not preclude me from investigating both formal and informal accountability relationships.

I reflect further on the basis of the typology, then present its' three 'types' of accountability which are taken forward to organise my data.

My use of Hupe and Hill's typology warrants some reflection on their consideration of Michael Lipsky's work on street-level bureaucracy (Lipsky, 1980). When I began analysing accountability in my own data and thinking about using the selected typology, I perceived that alcohol policy implementers in this research did share certain characteristics with Lipsky's definition of street-level bureaucrats (an assessment shared with alcohol policy scholars such as Nicholls [2015]). This informed my sense that Hupe and Hill's typology may be well-suited to my own analysis. For example, I perceived that Scottish alcohol policy implementers were acting with certain discretion and with severely restricted resources – key facets of Lipsky's conceptualisation of street-level bureaucrats. Additionally, they shared a status as stakeholders who act and make decisions in the public domain, and therefore may be held publicly accountable for their decisions and the resultant outcomes (Hupe and Hill, 2007). Finally, the way Scottish alcohol policy implementers' decisions, routines, and coping devices "effectively become the public policies they carry out" are similar to that described by Lipsky (1980, p. xii). However, I note a difference here – that many of the local implementers I interviewed acted as managers, more rarely being public-facing in the same way a traditional street-level bureaucrat might be seen to do. For instance, many of my interviewees had been promoted to management levels after having had an earlier career as a service delivery practitioner. Nonetheless, after engaging with more recent literature discussing street-level bureaucracy (discussed below) I assessed this difference did not prevent my use of Hupe and Hill's typology.

To explain, as my analysis progressed, I began to appreciate more contemporary critiques and interpretations of street-level bureaucracy, which located the work of policy implementers in more modern governance contexts. For example, authors such as Brodtkin (2012) and Durose (2011, 2007) have discussed how public sector governance has evolved since Lipsky (1980), observing a much greater emphasis on complexity, collaboration, and partnership across policy areas and sectors. Where Lipsky's writing is in a context of hierarchies, with street-level bureaucrats at the bottom practicing vertical accountability to those higher up the chain, authors have since identified the 'multiple accountabilities' public sector workers may

experience as a consequence of their embeddedness in complex governance structures (Durose, 2007; Schillemans and Bovens, 2011).

Hupe and Hill's (2007) typology, with its' grounding in Lipsky's work and synthesis of accountability and policy implementation considerations, stood out as being well-suited to my own analysis of accountability in Scottish alcohol policy implementation. However, I felt it was important to re-engage with it in light of these contemporary critiques. My consideration of Hupe and Hill (2007) in this light showed the authors remained committed to the notion of street-level bureaucracy, for example seeing value in employing the concept of a 'street-level' layer of implementation work. However, the authors did recognise the importance of the modern shift "from government to governance", and positioned their discussion of implementation and accountability "against this backdrop" (p. 279). To me, their engagement with re-interpreting and building upon Lipsky provided further indication that their typology may be well-suited to my research. For example, I perceived a key strength of the typology was Hupe and Hill's argument that local policy implementers experience accountability as a 'web' of relationships (not only vertical ones). The authors note that local policy actors are held accountable in a variety of ways, which go beyond exclusive accountability to the political centre (and may still include accountability to the public). Furthermore, that these different accountabilities, which sit in a context of multi-level governance, can be contradictory (Hupe and Hill, 2007). This acknowledgement of complexity made this typology additionally attractive, given my systematic review (Chapter 3) and early data analysis which suggested this complexity existed within the governance of local alcohol policy implementation.

Another strength was Hupe and Hill's (2007) challenge to Lipsky's relative neglect of key differences between street-level agencies – Hupe and Hill noted that agencies vary in their occupational make-up, functions, and tasks. Additionally, the authors discussed the importance of context in shaping these agencies' work, how public services are dependent on collaboration. To me, the authors' recognition of these complex factors spoke to the multi-sectoral, contingent, and collaborative nature of policy implementation, and felt relevant to my research because of the necessarily multi-sectoral, highly-contextualised nature of alcohol policy (World Health Organization, 2010; and Chapter 3). For example, this chapter and the next will explicate differences between ADPs and LBs, who, despite both contributing to

Scottish alcohol policy implementation, have important differences in the “nature of their tasks” (Hupe and Hill, 2007, p.283) and in the structural contexts in which they operate.

Despite the above-noted strengths of the Hupe and Hill typology, however, I reflected that it did not have a focus on ‘collective’ or partnership accountability. This was important in my research because the Scottish local policy context is characteristic of more contemporary governance – see, for example, its’ commitment to community planning (Chapter 2) and the influence of the Christie Commission (Christie, 2011) calling for partnership and joined-up working. In Scottish alcohol policy implementation, partnership and multi-sectoral working are key factors underpinning ADPs’ structure and their accountability relationships. Therefore, I reflect here that while Hupe and Hill’s typology remained useful for organising my complex data into ‘types of accountability’, I needed to adapt it to accommodate more explicit analysis about partnership working (p.183).

Further, while Hupe and Hill do acknowledge the potential for multiple types of accountability to be experienced at once, they did not discuss or demonstrate how the different types may be experienced simultaneously (and, for example whether a certain type may be experienced more strongly than others) or effectively navigated. Here I drew from Durose (2007) in observing that my interviewees took on a role that “emphasises pragmatism and negotiation and focuses on skills facilitated by local knowledge, experience, and networks” (p.213). This suggested that my analysis would need to consider how implementers negotiated experiences of multiple, potentially simultaneous (and possibly conflicting) accountabilities, and what aspects of their context (e.g. knowledge, collaborators, resources) may assist in this effort.

Considering the strengths and limitations of the Hupe and Hill’s typology, the utility and fit of it to my own analysis ultimately seemed robust, and I therefore used it to organise my data while, at the same time, considering potential limitations as my analysis progressed. The typology includes three types of accountability: ‘public-administrative’, ‘professional’, and ‘participatory’. *Public-administrative accountability* refers to traditional, vertical understandings of political, legal, and managerial accountability, in which the forum is an entity which is higher in the formal hierarchy

than the actor, who in turn reports to the forum. This is founded on the forum (e.g. courts, inspectorates, government departments, etc.) being seen to have “authoritative and legitimate jurisdiction” over the actor (Hupe and Hill, 2007, p. 288). Contexts in which this type of accountability relationship may be enacted are, for example, within a state’s legal system (Hupe and Hill, 2007).

Professional accountability is conceptualised by Hupe and Hill (2007) in terms of how implementers are held accountable by their peers, either within their chosen profession or related professions. This can include institutionalised self-regulation within particular formal professions – an intra-profession form of professional accountability (e.g. medical professions may self-regulate through horizontal, collective self-management within their ‘colleges’) (Hupe and Hill, 2007). Professional accountability can also be related, however, to more loosely defined ‘cooperation’ between people from different professions (Hupe and Hill, 2007). The latter conceptualisation seemed intuitively more appropriate for my purposes, given the way ADPs are constituted as partnerships involving multiple sectors and professions.

Participatory accountability is characterised by the involvement of citizens or clients, who can evaluate the work of local policy implementers. Hupe and Hill’s (2007) discussion of participatory accountability focuses mostly on local policy implementers and their clients, and they depict this type of accountability as being horizontally organised. However, they also note participatory accountability can be enacted in relationships between local policy implementers and, for example, national associations which represent some part of the population (e.g. patients), media, interest groups, associations, and citizens or voters (Hupe and Hill, 2007). Thomann and colleagues (2018) summarise this as capturing “expectations from society” (p. 300), and frame participatory accountability as resulting from the “shared *citizenship* of street-level bureaucrat and client” (p. 303, emphasis in original).

Hupe and Hill argue that each of the above types of accountability can be enacted in relationships between actors (here, local alcohol policy implementers, primarily ADP members) and forums at different ‘action scales’ or institutional levels: system, organizational, and individual (Hupe and Hill, 2007). However, the presence of multiple ‘action scales’ was not particularly evident in my data and my ensuing

analysis (in Chapters 5 and 6) therefore focuses more on distinguishing different types of accountability.

In this chapter and the next I analyse the accountability ‘regimes’ of ADPs and LBs, respectively. In each, I employ this typology to organise the results, with sub-sections focusing on Hupe and Hill’s different types of accountability. Within this chapter, Section 5.4.1 highlights my reflections on using the typology and suggested revisions for its use in the Scottish alcohol policy implementation context.

5.2 Results: National- and Local-Level Expectations of ADPs’ Role Implementing Scotland’s Alcohol Strategy

To contextualise the results in the rest of this chapter, it is important to briefly provide a sense of what the expectations were for ADPs, as suggested by my national-level data. National-level documentary data suggest that ADPs were formally intended to be a contributor to the Government’s whole population approach (Kleinberg, 2018; Scottish Government, 2009a), with a focus on developing local strategies and commissioning treatment services.

First, the guidance document *A New Framework for Local Partnerships on Alcohol and Drugs* (Scottish Government, 2009c) established ADPs³⁹. The *New Framework* outlines the roles and responsibilities of ADPs, and “aims to ensure that all bodies involved in tackling alcohol and drugs problems are clear about their responsibilities and their relationships with each other” (Scottish Government, 2009c, p. 2). It further states:

“the framework sets out the responsibilities of the Scottish Government and local government, NHS Boards, agencies and partnerships, and the accountability arrangements between them. It also sets out the capacity required, and support available, to enable partners to carry out these responsibilities.” (Scottish Government, 2009c, p. 2)

The more recently published *Updated Guidance for ADPs on Planning and Reporting Arrangements* (COSLA et al., 2015) states what ADPs’ responsibilities are, including that:

³⁹ Replacing ‘Alcohol and Drug Action Teams’ (Chapter 2).

“[ADPs] have a key role in delivering the national policy initiatives, the Alcohol Framework: Changing Scotland’s Relationship with Alcohol...” (p. 2)

Referenced in the quotation above, *Changing Scotland’s Relationship with Alcohol: A Framework for Action* (Scottish Government, 2009a) was the central policy to Scotland’s alcohol strategy during my study period. Reaffirming the quotations above, the *Framework for Action* also indicates that all alcohol policy stakeholders have a role in supporting the Government’s whole population approach, a view that was echoed by most national interviewees. One national interviewee emphasised this point by highlighting the Scottish Government’s support of other organisations (such as Alcohol Focus Scotland) so they can, in turn, support ADPs in their efforts to enact Scotland’s alcohol strategy:

“AFS has had a post funded [by Scottish Government] for about the last three or four years...it’s been about how [AFS] help Alcohol and Drug Partnerships to embed the whole population approach.” (National Level 1)

Some national-level interviewees offered a contrasting perspective, however, suggesting that the role of ADPs in Scottish alcohol policy was meant to be minimal, or narrowly focused, and that their goals were meant to be commensurate with their local-level remit of providing services to relatively small numbers of people. For example, one interviewee said they felt ADPs were not positioned to be key stakeholders in population-level changes related to alcohol-related harm:

“[ADPs] would not necessarily be focused on the broader social determinants of drug and alcohol issues because they were too small, they didn’t have enough power to do that...” (National Level 2)

The interviewees who had minimal expectations of ADPs emphasised their particular position in the governance system of alcohol policy implementation, one that is restricted by geographical territories and limited resources.

Despite this, overall the national document and interview data suggest that ADPs are expected to contribute to implementing the ‘whole population approach’ of Scotland’s alcohol strategy. However, these data do not provide a clear sense of *how* ADPs were expected to do this, which emerged as being a potential source of ambiguity for ADPs.

At local level, interviewees across and within the three local areas often gave different descriptions of how they perceived the role and goals of their ADP. Before discussing this data, I note that ADPs broadly discussed similar concerns and portfolios of work stemming from the alcohol strategy and broader policy priorities, for example finding cost savings, developing 'recovery-oriented systems of care', and meeting delivery targets for ABIs and waiting times. However, importantly, ADP interviewee data also demonstrated some variability in each ADP's primary focus. For example, LA1 interviewees tended to express a focus on trying to influence local alcohol licensing, given their reported perceptions that the area was overprovided for. In contrast, LA2 interviewees tended to emphasise their work to engage service users in local consultations, a recovery café, and peer research. Finally, LA3 interviewees also emphasised their work on engaging with service users but additionally spoke frequently about their work to provide diversionary activities for youth.

In response to questions about how they perceived the role and goals of their ADP, responses variously described the ADP as: a contributor to Scotland's whole population approach; a partnership to bring together relevant organisations whose work could influence alcohol-related harm; a commissioning body for alcohol and drug services; a community- and recovery-focused organisation; or simply a forum where ideas about addressing alcohol-related harm could be shared. To illustrate the latter:

"the ADP, it's like a collection of stakeholders...it's a consensual forum where people with interests try to get together to make things better within the constraints that they're operating in." (LA1, local councillor)

The above data points to a range of perspectives on ADPs' roles, potentially suggesting a lack of clarity, or flexibility, in how ADPs are expected to operate. I additionally note, however, that interviewees represented their perceptions of these roles not as fixed and static, but as relatively loosely defined and potentially overlapping. It is against this backdrop that, overall, the data suggest ADPs have a key function as local implementers of the 2009 alcohol strategy, and it is in relation to this that their accountability(ies) will be explored.

5.3 Public-Administrative, Professional, and Participatory Accountability of ADPs

The following subsections present an analysis of how ADP members experience accountability, organised using the Hupe and Hill (2007) typology. Table 5.1 depicts a hypothetical summary of potential ‘forums’ with whom ADPs may experience an accountability relationship. Reflecting the data, I focus on: public-administrative accountability to Scottish Government; professional accountability between partners on the ADP; and participatory accountability to service users and citizens.

Table 5.1 Potential forums for ADP accountability

Forums of accountability (modified from Hupe and Hill 2007)		
Public-administrative accountability	Professional accountability	Participatory accountability
Scottish Government or Parliament, Community Planning Partnership, Care Inspectorate	Peers/Partners on ADP	Service users, carers, citizens, residents, etc.

5.3.1 Public-Administrative (Vertical) Accountability of ADPs

As discussed earlier in the chapter, Hupe and Hill (2007) use ‘public-administrative accountability’ to describe types of accountability relationships which represent traditional, vertical or hierarchical approaches to accountability. Within this, the accountability ‘forum’ is a legitimate, authoritative body which is higher in the formal hierarchy than the ‘actor’ (here, the ADP), who in turn reports to the forum (in this case, the Scottish Government). The data in this section are presented in three subsections, which discuss: (i) whether ADPs are accountable to the Scottish Government for implementing the 2009 alcohol strategy; (ii) what ADPs are accountable to the Scottish Government for; and (iii) how ADPs are held accountable in a context characterised by differing expectations and partnership working.

Identifying Whether ADPs are Accountable to Scottish Government

The previous results section (5.2) concluded that ADPs were expected to contribute to implementing Scotland’s alcohol strategy. This subsection presents data that

examine *whether* strategy documents and actors involved in establishing ADPs envisaged ADPs as being accountable to the Scottish Government for implementing the strategy. The data from interviews and documents suggest there was a lack of clarity about this. Two conflicting perspectives were identified. The first viewed no (or minimal) accountability to Scottish Government, with Government instead being a source of 'support' for implementation (a perspective more often expressed by national interviewees). In contrast, the second perspective saw clear and formal accountability to Scottish Government (more often expressed by local ADP interviewees). As will be shown with data below, the contrasts in these perceptions may help explain the confusion and miscommunication which characterises ADPs' accountability regime.

The data in this subsection were often particularly insightful when the accountability mechanism of 'reporting' was discussed. Reporting is one of the most basic ways to observe accountability between an actor and a forum (Dubnick, 2005). The results from the documentary analysis suggested that ADPs were indeed positioned by national policymakers as being responsible for reporting annually to the Scottish Government on progress towards specific targets and outcomes that have been set at national level (COSLA et al., 2015). This includes a range of measures discussed in Chapter 2, including ADP Core Outcomes and *The Quality Principles* (Scottish Government, 2014, 2013), as well as relevant measures from the broader policy landscape (e.g. the NPF). These reporting responsibilities were also mentioned by local interviewees (discussed below from page 159).

However, some of the national level interviewees explicitly said that ADPs are not accountable to Government:

"ADPs are not accountable to the Scottish Government...that has always been the case. And that has meant that there is a fairly unusual relationship there, in accountability terms, in that the Scottish Government has provided funding, via health boards to ADPs. But, has asked for a degree of evaluation to take place, and for the outcomes of that evaluation to be reported back to the Scottish Government. But that's really without any formal line of accountability, from ADP to Government. So that reporting has been variable, and in some instances, fairly light touch, in terms of what has been requested." (National Level 7)

The quotation above illustrates how confused the messaging from Scottish Government to ADPs can appear to be in relation to accountability. The quotation indicates ADPs are not formally accountable to Scottish Government, but additionally that Government seeks to retain oversight of ADP work and outcomes (although this is framed as a 'request') – the latter potentially indicating an informal accountability relationship. Further, the quotation hints that the Government's approach to their relationship with ADPs may have led to variability in ADP reporting, suggesting that ADPs have exercised flexibility in interpreting the level of reporting that is required. Further, with the mention of funding, the quotation provides initial indication of a national-level narrative that the Scottish Government is mainly supposed to be a source of 'support' for ADPs (discussed further below).

Some national policy documents also represent ADP reporting to Scottish Government as fairly minimal. For example, the quotation below from the *Updated Guidance for ADPs on Planning & Reporting Arrangements* seems to suggest that ADPs are only indirectly accountable to the Scottish Government, and again represents Government's oversight of their work as being relatively 'light':

“ADP accountability is via [Community Planning Partnerships] (and for HEAT targets/standards via Health Boards), rather than directly to Scottish Government. The Scottish Government will offer light feedback to individual ADPs on Annual Reports and Delivery Plans.” (COSLA et al., 2015, p. 7)

This describes a governance approach in which the Scottish Government seems to try to shift accountability to local government, while still retaining reporting relationships with ADPs. What constitutes 'light feedback', and whether responding to this feedback is optional for ADPs appears unclear. Further, while the national documents embed ADPs' work in Scotland's wider arrangements for 'community planning' (Scottish Government, 2009c), and briefly note ADPs' accountability to their Community Planning Partnership, the specifics of this relationship to the local actors appear to be delegated to local level. For example, the *Updated Guidance* states:

“your [Delivery] Plan should articulate your ADP's relationship with the Integrated Joint Board (IJB)⁴⁰ as well as your ADP's ongoing relationship with your Community Planning Partnership

⁴⁰ The document is referring to a type of 'integration authority' created through local policy reforms following the *Public Bodies (Joint Working) (Scotland) Act 2014* (see Chapter 2).

(CPP)...Your plan should indicate through what route and with what frequency your ADP reports and advise how often you expect to receive feedback” (COSLA et al., 2015, p. 10)

From the documentary analysis and local interview data, it does not appear that more specific guidance has been provided to ADPs about this local accountability relationship, and local interviewees spoke infrequently about their relationship with the Community Planning Partnership (only half mentioned this Partnership at all). However, this may have been a consequence of the interview structure – while I did ask about ADPs’ general relationship to other local structures like the Partnership, I did not ask explicitly about ADP accountability to them. Of the data which discussed this, interviewees either simply indicated they had reported as an ADP to the Community Planning Partnership in the past, or represented the relationship as being in flux as a result of the current organisational changes being made regarding health and social care integration. For example:

“I’m asked to give an update on what the ADP’s doing and answer questions and whatnot. I think it could be more...it could be a more robust relationship because we’re expected to get feedback from the Community Planning Partnership, but we don’t really get an awful lot of feedback from them.” (LA3, ADP Member)

“The ADPs were set up to be a reporting arm of the Community Planning Partnerships. But we’ve now lost sight of that because, as well, there’ll be inconsistencies right across Scotland in terms of the ADP reporting structure, but as you know we are now reporting into the Health and Social Care Partnership even though the ADPs were set up to report into the CPP. And we’ve probably touched on this before, the Health and Social Care Partnership are still to get their house in order, so they’ve not really given us any kind of direction about what they need from their ADP.” (LA2, ADP Member)

“The ADP reports to [Local LA3 Safety] Partnership, which reports up to the overarching Community Planning Partnership. That whole structure is under review - there are negotiations ongoing around exactly what format that’s going to mean in terms of a redesign of the reporting structure with a smaller number of Community Planning Partnerships and Single Outcome Agreements.” (LA3, ADP Member)

From these quotations it appears that, while some ADP members acknowledged their reporting responsibilities to Community Planning Partnerships, this situation was undergoing substantive changes which led ADP members to depict fluid and uncertain relationships rather than clear lines of accountability. Overall in my data

corpus, and particularly the national documents, the richest and clearest data regarding accountability focus primarily on the Scottish Government's expectations of ADPs and how they work within local and national policy contexts.

Returning to this ADP-Scottish Government relationship, data from documents and national interviews suggested there was a perception that Government would be seen as a broader support for ADPs and their local policy implementation work. This narrative regarding the Scottish Government as a source of 'support' arose within the data as an alternative to the idea that ADPs would be held directly accountable to them. As outlined in Chapter 2, the Scottish Government supports local alcohol policy implementation through the provision of funding. The government also provides funding to organisations such as Alcohol Focus Scotland, who have a role in providing additional support by working directly with local areas. Further, the *New Framework for Local Partnerships on Alcohol and Drugs*, states that the "Scottish Government...should support these partnerships to achieve agreed local outcomes." (Scottish Government, 2009c, p. 4). Contained in key guidance for local implementers, these types of statements seem to identify the government as being a potential source of support beyond only financial maintenance.

While the above data provide examples of the Scottish Government positioning itself as a source of support, and claims that the reporting requested is minimal, some of the interviews presented a contrasting perspective. They suggested a more rigid, strongly imposed accountability relationship between Scottish Government and ADPs is sometimes enacted. For example, some national level interviewees indicated the reporting regime is rather stricter than the above data suggest, while recognising the confused messaging around lines of accountability, which they suggested was problematic. To illustrate:

"We were walking that...line when we were developing that and those outcomes and indicators for ADPs, sort of, couching it as in, you haven't really got a choice about reporting on this...[...].there was a conversation I remember having with colleagues who were working in the improvement team within Scottish Government about you're creating a problem here because you're trying to hold [ADPs] to account but at the same time you're trying to... encourage them and support them" (National Level 1)

These data suggest that Government wanted to be perceived as a source of support, but that much of this 'support' was by maintaining reporting structures that have their own underlying tensions. Data from documentary sources illustrate this further. For example, a letter regarding funding allocations was received by ADPs in July 2016 from the Scottish Government (Kleinberg, 2016), which I attained while mapping ADP funding (Chapter 2). The letter states that funding provided to ADPs is conditional upon them demonstrating progress towards national and local outcomes and Ministerial priorities. Further, that:

“Scottish Ministers reserve the right to withdraw all or part of this funding if funds are not used for the purpose intended; if improvement/activity is not demonstrated; or if value for money is not demonstrated” (Kleinberg, 2016, p. 3)

The 2017-18 version of this letter contains the same statement (Kleinberg, 2017b), and the 2018-19 version (while not including the exact statement above) notes that funding provided should be “invested transparently, informed by a robust evidence base and appropriate needs assessment” (Kleinberg, 2018, p.1). Further, the quotation above is in contrast to the narrative of Scottish Government primarily being a source of 'support' to ADPs – while support may be provided financially, these communications suggest ADPs can be penalised if their conduct is not judged as being sufficient – key components of an accountability relationship.

The national-level data above has illustrated contrasting perspectives about the extent to which ADPs are accountable to Scottish Government. At local level, however, ADP interviewees were more consistent in reporting that they did perceive themselves to be accountable to Scottish Government. First, ADP interviewees reported feeling accountable to the Government because of the funding they receive, above and beyond their formal accountabilities to their local area hierarchy. For example:

“...the ADP feel they are accountable back to the government in terms of the funding that they get.” (LA2, ADP Member)

Further, interview data from ADP members were in contrast with the reported narrative of Scottish Government as a source of 'support' for ADPs. For example, a member of the ADP administrative team in LA2, after explaining her/his disappointment with Government feedback on their most recent annual report, provided the following, rather blunt statement of how this felt:

“we are not getting any support from the national level.” (LA2, ADP Member)

This perceived lack of support for implementation was primarily reported in relation to the substantial amount of reporting ADPs were expected to carry out on an ongoing basis. The below quotation provides data that contrasts with the ‘light touch’ perspective on reporting suggested by the national-level Government data:

“So the ADP has a Strategy...it has action plans, it’s relentless, actually. The [ADP] coordinator has to feed the Scottish Government quite a lot of information because of the treatment target.” (LA3, ADP Member)

An illustrative example of the weight of reporting required by ADPs came with the Scottish Government’s 2014 introduction of, and efforts to monitor, *The Quality Principles* (Scottish Government, 2014b). The Principles were developed to provide standard expectations of care for alcohol and drug services, for example ensuring quick access to services and high-quality, evidence-informed treatment (Scottish Government, 2014b). Multiple local interviewees from across ADP member organisations reported that the Principles were aligned with their existing work and values, for example that the Principles simply reflected basic social care values. Despite this, the introduction of this policy came with substantive additional reporting requirements for ADPs:

“the work around Quality Principles, each service was asked to do a self-assessment around that, and had to do a report...so that’s been a massive piece of work for us at the moment.” (LA2, ADP Member)

Further, despite having reportedly consulted with ADPs during development of *The Quality Principles* (Scottish Government, 2014b), it seems that the formal accountability mechanism surrounding the Principles was subsequently implemented in what was perceived by interviewees to be a strongly top-down manner, with little or no consultation. This approach included introducing in-person inspections of ADP work by the Care Inspectorate (Care Inspectorate, 2017), with the first inspections to be conducted in 2016, only a few months after the announcement. Some concern, even outrage, was expressed by interviewees about the expectation that they engage with the Care Inspectorate in this way, especially those from LA2 (which may have been because their inspection coincided with the interviews I undertook).

“You’re basically, you’re crippling, you’re crippling us with what you’re expecting. It’s so disproportionate it’s unbelievable, did they listen? Fell on deaf ears big time. And this was a meeting where we had been told that 22% of any ADP budget was being reduced.” (LA2, ADP Member)

This quotation provides a forceful account of the intersections of pressures local implementers perceive in public-administrative accountability, and seem to directly contrast with some of the national-level perceptions that Scottish Government oversight would be ‘light touch’ and ‘supportive’. Some of the interview discussions suggested that performance measurement obligations were so great that they had begun to monopolise the time and capacity of local implementers, a finding aligned with Chalmers and colleagues (2016), who found a similar challenge in the Australian alcohol services context (see Chapter 3). In the following extract, a local implementer reports frustration with this situation:

“We do report to the Scottish Government every year, and you get feedback on it. But actually does it mean anything?... I’m saying to [ADP Coordinator], trim it down a bit, ‘cause...we’re doing all this work, we’ll tell the Government, and actually it’s a paper exercise, it’s really not going to mean much...we got the feedback on it and we sat down with the feedback, and thought ‘they don’t understand what we’ve told them’...What a complete waste of time. You know, of course they’re the paymasters, of course they have to be satisfied” (LA2, ADP Member)

This quotation further underlines the sense that ADPs appear to be navigating a pressured situation in which they experience accountability to the Scottish Government, but do not necessarily feel supported to effectively engage with or meet such expectations. This suggests that, in their work to implement the alcohol strategy, this aspect of their accountability regime is a source of confusion and frustration.

Public-Administrative Accountability of ADPs: Examining what ADPs are accountable for

So far, we have seen that the data suggest ADPs are accountable to Scottish Government in practice, despite a narrative at national level to frame the relationship in more supportive terms. I now explore the accountability relationship between ADPs and Scottish Government further by investigating what ADPs are being held accountable *for* (e.g. contributing to achieving targets). It is important to consider

what ADPs are accountable for because this influences what they prioritise in their implementation work.

The data initially suggested an emphasis on working towards nationally-agreed targets. For example, the 2018-19 letter to ADPs from the Scottish Government noted that ADPs had certain 'compliance requirements', which included two 'Local Delivery Plan Standards': the 'Drug and Alcohol Treatment Waiting Times Standard and the Alcohol Brief Interventions Standard' (Kleinberg, 2018). However, this letter did not outline whether 'compliance' for these Standards meant ADPs would be formally held accountable for their contributions towards these. These considerations were explored further in the local interview data, in which interviewees consistently reported that they felt responsible for meeting national level targets:

"Alcohol brief interventions, there's an evidence base which we have researched and the expectation is, you know, that each ADP or Health Board area will promote that and deliver that. And there's been obviously [national ABI] targets that have been set and the expectation of meeting them." (LA2, ADP Member)

Additionally, when one interviewee spoke about a locally-developed recovery initiative, I asked whether s/he thought this initiative worked towards targets from national level. In response, s/he spoke about how national pressures permeate her/his thinking during this type of work:

"I think [national indicators] are helpful because they keep you focused, and particularly there's a huge recovery focus, huge family involvement focus, and I think sometimes you tend to get blinkered and set in your own...this is what we're doing, this is why we're doing it. I think we need these things to remind us that there are wider support networks, etcetera, out there that we should be tapping into, and I think when you know that that's being looked at, it makes you more conscious of the direction." (LA2, ADP Member)

The quotations above suggest that performance measures such as indicators or targets seemed to serve as an accountability mechanism which influenced local decision-making and prioritisation.

Importantly, however, the data regarding reporting against national targets was discussed in relation to a context in which significant resource cuts were being made:

“You can't do that [budget reduction] without losing posts, you can't lose posts without losing some capacity, you can't lose capacity without waiting times increasing, but there's meant to be no impact on the waiting times target...and that starts to become, you know, somebody's psychotic here and it's not me...So policy is fine provided the carpet [i.e. resources] is not pulled out from under the people who have to implement policy” (LA1, ADP Member, NHS)

...we are in a situation at the moment where the level of cuts that we're being required to make are eye watering and completely unprecedented...I think we have to accept that the public services envelope, financial envelope, is just reducing to a point that if we continue, or if we try or want to continue doing everything that we've done before, it's just completely unsustainable, we can't, we are not going to be able to do it. (LA1, ADP Member)

“...[the way treatment services are set up] you can't really have a proper conversation about at the meetings because people get defensive about their budgets and about the priorities...it's always about money, isn't it? [...] every year we're being told more and more about budget cuts and how we've got to do things with less. (LA3, ADP Member)

These quotations strongly signify the importance of resources for ADPs' ability to implement Scotland's alcohol strategy – a finding which is consistent with the importance placed on resources in other studies of alcohol policy implementation, as demonstrated in the results of the systematic review (Chapter 3). Further, despite the clarity evident in the data regarding the significance of targets, a lack of clarity about other responsibilities emerged – appearing to relate, at least in part to the confusion observed over ADPs' roles (Section 5.2) and to how the Scottish Government communicated with ADPs.

The topic of commissioning is also illustrative in exploring the sense of confusion about what ADPs are being held accountable for by the Scottish Government, and how this lack of clarity presents a challenge to their work implementing its alcohol strategy. At national level, relevant policy documents suggest that ADPs are responsible for commissioning local treatment and services. For example, the Scottish Government's *New Framework for Local Partnerships on Alcohol and Drugs* states that “Each local alcohol and drug strategy should...set out an approach

to the commissioning and delivery of services...” (Scottish Government, 2009c, p. 7). Further, the Standard Reporting Template for ADPs’ annual reports has multiple references to ADP commissioning work (COSLA et al., 2015). For instance, it requires ADPs to link their “strategic commissioning work” to other local community planning (COSLA et al., 2015, p. 32). However, national guidance about commissioning contained in the *Framework for Action* is much more limited, stating only that local commissioning decisions should be “shaped by the priorities identified by ADPs” (Scottish Government, 2009a, p. 24).

National-level interviews showed variable perspectives about whether ADPs were expected to engage in commissioning work. Some agreed they were, with one interviewee stating that “ADPs primarily are commissioning services” (National Level 4). However, one national interviewee was hesitant to define ADPs as having a commissioning role, because s/he perceived them to be primarily a partnership which brought together stakeholders who themselves already provide alcohol-related services, such as NHS and third sector. S/he perceived that the ADP ‘commissioning’ was actually ‘buying’ those services from these stakeholders (who are also represented on the ADP).

The relative degree of uncertainty at national level around ADP commissioning seemed to inform local confusion about whether ADPs were accountable for commissioning and how their accountability for this work was being communicated. Interviewees across the LAs spoke about their perceived responsibilities for undertaking commissioning in different ways – from seeing it as a central task of the ADP (LA1) to being a minor aspect of their remit (LA3). For example, in LA1, one interviewee described their primary role on the ADP as being focused on commissioning services, placing this as a central activity of the ADP overall and describing it in the following terms:

“What I tend to do now is fairly specifically about...what outcomes we’re looking for from our system of care and managing the contracts for the people who are doing the treatment.” (LA1, ADP Member)

This interviewee suggests that a central aspect of their ADP-related role, and thus what they are held accountable for, is to commission treatment services. This interviewee’s mention of outcomes also indicates that they perceive their

responsibility for commissioning as being linked to their accountability for progress towards key outcomes. It was also notable that LA1 had established a working group on commissioning and had designated a member to focus on this activity (i.e. it was clear that it was not only the above interviewee but the ADP, as a partnership, which saw commissioning as a core part of its role).

The other two local areas, however, reported rather different perceptions of their commissioning responsibilities. Interviewees in LA2 suggest that they did see commissioning as one of their responsibilities, but that there is a tension between their commissioning responsibility and their lack of *legitimacy* as commissioners. For example, an ADP member in LA2 described feeling that the culture towards ADPs from statutory bodies (who are also ADP members) is to view the ADP simply as a source of funding, and whom s/he perceived as treating the ADP with “contempt”. This same interviewee further described the history of ADPs, in terms of funding and priority being weighted towards statutory services:

“Going back to historical backdrop of [being] heavily weighted towards statutory services, that really just see us [ADP] as a cash cow, and until that changes...I don't think we're gonna be respected commissioners.” (LA2, ADP Member)

Such descriptions illustrate that statutory services are members of the ADP but also seem to take priority over non-statutory services, creating a potentially problematic relational imbalance within the partnership. There appears to be an important distinction between statutory and non-statutory services, and the different perspectives and resources they have. Here, the interviewee suggests that as a non-statutory body, the ADP is not perceived as a credible commissioner for services by statutory organisations.

In LA3, interviewees seemed to either perceive commissioning was not a primary role of the ADP, or that there was ‘confusion’ about this aspect of the ADP’s role. The quotation below helps to illustrate this, and the potential tension arising from this perception sitting alongside efforts to hold ADPs formally to account for commissioning:

“Our ADP I think, unlike some other ADPs around the country, doesn’t do an awful lot of commissioning work – I know that some ADPs actually commission services, ours doesn’t do that yet, or if it does, it’s very, very little [...]To have the ADP commission, in a

formal sense, would require quite a bit of change in terms of how the government has set them up and how the government holds different bodies that sit round the ADP to account...I don't know if our ADP are [sic] different to other ADPs" (LA3, ADP Member)

The interviewee also acknowledged how LA3 may be different from ADPs, however, and attributed this to "the way services have been set up", which they described as "very different, historically", suggesting variation across Scottish ADPs may be somewhat path dependent. Ultimately, this interviewee went on to suggest that the ADP's primary responsibility was to provide a space in which members could discuss on alcohol policy priorities and work in partnership towards these. A third sector representative to the LA3 ADP summed up the confusion regarding this topic:

"There's a lot of confusion about whether they have a commissioning role or not. It's been a discussion that's been going round for years and years... And they don't really have a commissioning role at the moment. And that's one of the things that's, kind of, controlling the whole situation. 'Cause a lot of the assumption is that the money is NHS money. And that's very much a convention here, that it is seen as NHS money." (LA3, ADP Member)

Indeed, in this local area, interviewees (particularly NHS representatives) who reported the ADP did do some commissioning reported this as being more about negotiating local agreements (given the non-statutory nature of the ADP), because it was actually the NHS which holds the funding for this commissioning.

Overall, it seems that while certain ADP responsibilities (e.g. pursuing national-level targets) were clearly understood across all three ADPs perspectives on other aspects of their role - and thus what they reporting feeling they would be held accountable for - varied between local areas and was a source of confusion.

Public-Administrative Accountability in the Context of Partnership Arrangements

It was evident from the data that the accountability relationship between ADPs and Scottish Government was complicated further by key characteristics of ADPs' structures as partnerships. ADPs exist because the Scottish Government mandates that local alcohol (and drugs) policy implementation stakeholders form and maintain partnerships (Scottish Government, 2009c) (see Chapter 2). National level policy

documents provided an initial sense of how these partnerships were expected to be held accountable:

“The governance and accountability arrangements for these partnerships should be consistent with existing accountability arrangements between the Scottish Government and local partners - chiefly, [Single Outcome Agreements] between Government and [Community Planning Partnerships]; and the NHS performance management arrangements” (Scottish Government, 2009c, p. 4)

This quotation suggests accountability for ADPs is intended to be operationalised at the level of individual organisations, feeding back into established, traditional lines of accountability, via Community Planning Partnerships and NHS bodies. However, the more recent national document, the *Updated Guidance for ADPs*, suggests that responsibility for implementation of the alcohol strategy would be jointly shared between members of each ADP, stating:

“Partners are jointly accountable for delivery of the ADP outcomes within this financial framework.” (COSLA et al., 2015, p. 6)

The *Updated Guidance* does not give further explanation for how this apparent shift from individual organisation accountability to joint partnership accountability is intended to be operationalised, nor why it has occurred. In some ways, this collective accountability of ADP partners seems reasonable, given that ADPs are supposed to collaboratively implement alcohol policy. However, the extent to which this approach faces challenges was strongly evident in the data, with the majority of ADP members across the participating local areas suggesting they felt the way the Scottish Government has enacted this ‘joint accountability’ was inappropriate for a local, non-statutory, multi-agency partnership. For example, the following ADP member indicated they felt that Scottish Government perceived ADPs in a way which was inconsistent with their structure and remit, and that this was problematic for the relationship between the two:

“The Scottish Government write to ADPs as if they’re part of an NHS board, and they ask questions of us and they hold us to account and they seek documentation and plans, and they meet with us as if we’re part of an NHS board and they don’t really understand the partnership. It’s as if sometimes the ADP is another agency, a separate agency that has its own governance and accountability. It doesn’t have any of that, it’s just the agencies, the partners sitting around a table, but that’s not how it’s regarded by government.” (LA3, ADP Member)

This quotation suggests that the Government's apparent conception of ADPs as a separate organisation poses a challenge to effective communication; the interviewee suggests that such an approach does not fully appreciate where ADPs are positioned in the governance system or what their capacities are. This quotation also lends further support to the results above, which suggest that the Scottish Government is enacting a direct accountability relationship with ADPs. The data make clear that this approach does not sit comfortably with ADPs given it differs from stated expectations regarding Government acting as a 'support' and does not appear to take account of the fact ADPs are partnerships of multiple statutory (and non-statutory) bodies.

Indeed, interviewees across all three local areas raised concerns that ADPs were being held collectively responsible for activities that the partnership members undertake individually and/or beyond the partnership (e.g. by NHS bodies, Police Scotland, etc.):

"So we partially fund NHS things and yet we are held accountable for things that the totality of the NHS do, the NHS are reporting on stuff that we partially fund, I think there's real muddle, no clear lines of accountability, which I think makes it more difficult to deliver on the policy." (LA2, ADP Member)

"I think there are challenges around – I've talked about it all the way through – accountability and governance. I can't quite get my head around Scottish Government's thinking around holding ADPs to account for things that are delivered by a single organisation that's part of that ADP. I think that needs to be sorted out, it seems bonkers to me that they continue to do that." (LA3, ADP Member)

Another interviewee suggested that decisions to fund some services on a partial basis created further confusion about what the ADP would be held accountable for and how governance approaches related to this:

"We're supposed to report back on alcohol brief interventions for example...but we partially fund two or three areas that deliver a lot of these ABIs in key areas, for example, through midwifery and through GPs. But we don't fully fund that. So if we're not successful then who's actually accountable for that? [...] What I would welcome is the government saying to me, 'right, see that £1.6 million budget, actually we're going to cut that in half. You're getting £800,000 but here's what you're going to do. You're going

to go do that forward facing, community based, prevention work. See all the stuff you invest in treatment just now? That's the NHS are delivering that, why are we trying to hold you to account as an ADP for that?' Why are you expecting me to influence the NHS, to do government policy, which is government policy for the NHS as well?" (LA2, ADP Member)

In contrast to their preferred approach, outlined above, this interviewee described their actual experiences as substantially circumscribed by major resource constraints:

"I look at our budget...80% odd goes to the statutory bodies who deliver. Now some of that is absolutely how the money should be spent, I've got no qualms about that at all. But then you look at the ADP itself and say, well, it's heavily populated by NHS and Council employees who have targets, who have things they have to do, who rely on money from the ADP to achieve those targets. Not all of which are the ADP targets." (LA2, ADP Member)

This suggests that, given some of these organisations rely on ADP funding to meet their own, separate targets, there may be a conflict of interest for some members in their engagement with ADP funding decision-making. Such data identify a range of challenges with holding ADPs accountable as a partnership and highlight the challenges faced by ADPs as partnerships comprised of representatives from a range of different organisations.

Overall, the data regarding public-administrative accountability between ADPs and Scottish Government suggests current arrangements may require reconsideration. However, it was unclear how (or whether) this might happen since both national and local level actors expressed some sense of powerlessness to change these arrangements.

5.3.2 ADP Professional (Horizontal) Accountability

Professional accountability is described by Hupe and Hill (2007) as examining horizontal accountabilities, specifically those which exist between officials and their peers at local level. However, Hupe and Hill (2007) did not discuss this type of accountability within the context of multi-sectoral partnership working, which is clearly an important consideration for this research.

Discussion of concepts related to professional accountability was relatively limited in my analysis of national documents. For example, the *Framework for Action* (2009) merely notes that “everyone has a part to play – whether in central government, local government, the police, the health service, the third sector, alcohol producers or retailers and the public” (Scottish Government, 2009a, p. 7). The document does not, however, discuss how local implementers should be interacting with each other in terms of accountability.

The stated aim of the 2009 *New Framework for Local Partnerships for Alcohol and Drugs* is to “ensure that all bodies involved in tackling alcohol and drugs problems are clear about their responsibilities *and their relationships with each other*” (Scottish Government, 2009c, p. 2 emphasis added). However, this *New Framework* goes on to focus on how ADPs are collectively accountable contributing to meeting performance management targets and to other local accountability arrangements such as Single Outcome Agreements [see Chapter 2]. It does not provide guidance on how professional accountability should be undertaken within the partnerships, beyond stating that local authorities, Health Boards, and other relevant local partners should participate fully in local partnership arrangements. For example:

“Each local authority and NHS Board should.... ensure that these partnership arrangements enable them to meet their respective responsibilities to account to the Scottish Government, *other partners* and the public...[and] ensure that these partnership arrangements enable the appropriate involvement of other local partners with a potential contribution to make to the achievement of agreed local outcomes...” (Scottish Government, 2009c, p. 6 emphasis added)

Additionally, the 2015 *Updated Guidance for ADPs* demonstrates a focus on ADPs’ accountability to their superiors in the government hierarchy as opposed to intra-partnership accountability (COSLA et al., 2014). What guidance does exist from policy documents therefore seems to suggest that professional accountability decisions are primarily left to local actors.

Among national level interviewees, only a minority discussed aspects of ADPs’ partnership working, and none discussed how professional accountability may work in this context. Only one national level interviewee explicitly reported on general

challenges they perceived ADPs to be faced with when enacting partnership working:

“The trouble is ADPs, like all of these things, there’s some great ones and some not so great ones, and I think partnership working is always a really troublesome thing to do, because if someone doesn’t want to play with you they won’t. So real partnership working is hard going.” (National Level 6)

Another national level interviewee recognised the added complexity that the partnership approach involved, however did not further link this to challenges:

“[Scottish alcohol policy] moved towards this model of Alcohol and Drug Partnerships, saying that they needed to be strategic partnerships embedded in community planning...I suppose it’s a bit like these Russian [nesting] dolls, isn’t it, you’ve got the national strategy and then you would hope that you’ve got community planning partnership approach.” (National Level 1)

Overall in the national policy documents and interview data there appears to be a lack of national guidance about how professional accountability should be enacted in ADPs. In light of this lack of national guidance, it is perhaps unsurprising that the evidence suggests there is variation in how ADPs were performing professional accountability. While interviews with ADP members suggested some consensus about the need for, and benefits of, partnership working, responses about how they perceived the current quality of professional accountability in their ADP revealed a wide range of perspectives. For example, the following interviewee, a senior manager from LA2, expressed a broadly positive view:

“I think folk are accountable and report back to the ADP and I think there’s clear actions that come from meetings of the ADP, that people have to work on so I’m quite satisfied that it operates well.”
(LA2, ADP Member)

Most local interviewees, however, provided much more negative accounts of within-ADP accountability. This included an exchange from a colleague of the above interviewee, in LA2:

“A failure on our part is, see the sub-group activity, it is appalling. The activities are probably really great out there. I don’t know about it though, and they’re terrible at bringing it forward. So we don’t know what is going on...People are just not reporting back and I keep on banging the drum to that [ADP Executive] to say,

'well youse'⁴¹ [sic] are senior managers. These are your services, what are youse doing to help me to get this information?" (LA2, ADP Member)

This quotation suggests the interviewee perceived senior managers to be lacking in their professional accountability support to the ADP (i.e. that managers were not using their influence in their respective organisations to ensure that their services were fulfilling reporting requirements to the ADP). The quotation above, from a senior manager in the same local area, however, suggests that this message has either not been received or has been ignored/discounted at senior management level. The following exchange with an ADP member from LA1 demonstrates a similar frustration – the interviewee highlights the challenges of attaining information from the (statutory) NHS, and compares this with a very different arrangement the ADP has with the third-sector services they have commissioned. All of this is also intertwined with resource-related issues:

Interviewee: "Inter-organisational things within how the partnership work are very big considerations...The way that funding is allocated to different parts of the services are different. The money gets given to the NHS as bankers. They're just supposed to give it to us to run [services]. Historically what they actually did was take what they needed to run their services, say, 'no these are the important grown up services, these are the things that count, these have the evidence base, this is the, this is the seriously important stuff', and then trickle out what was left to be delivered under a strategic plan. [...] So then it comes to the Partnership who then get what's left over and we commission under contracts mostly, with we have theoretical contracts with the NHS – "

AW: "What do you mean by a theoretical contract?"

Interviewee: "It doesn't matter if they break them. If we tell them this is how much money we're spending and this is how many people we want, and you need to report back to us how many people you saw, they just don't report, and that's ok 'cause they're the NHS. Whereas if you did that in the voluntary sector and we were funding you on a three-year rolling contract that says this, this, this and this, we'd just pull the money if they didn't [report back] ... My biggest frustration is...that I don't know how many clients there are in the NHS, so we give them money, but I don't know how many clients there are" (LA1, ADP Member)

This interviewee is part of the full-time administrative ADP team, and seems to perceive different levels of effectiveness of horizontal reporting than interviewees

⁴¹ Colloquial Scots for 'you' (usually more than one person)

who were part of the ADP representing another organisation. It may be that 'central' ADP members have more specific insight into the issue of horizontal reporting because they are individually responsible for coordinating it and thus potentially more aware of existing challenges.

Local interviewees reported further challenges related to partnership working. For example, that this approach did not guarantee the work of the ADP would feel aligned with each members' work for their own organisation. The below quotations from different ADP members in LA2 help to illustrate this:

"What I'm trying to do just now, and again this is what I think we need [to] work better as a partnership, you know I've got 4 or 5 subgroups in the ADP structure...how it should work is those subgroups should drive activity. Whereas the feeling I get, is that actually the subgroups is people doing their jobs for the agencies they work for coming together to have a chat, and going away and working for the agencies they work for." (LA2, ADP Member)

"...it can be difficult, because everybody leaves that table and goes away to manage their own services, in the best way that they can. Which immediately then falls back into their local priorities, and local governancing [*sic*] arrangements. And that can be very difficult to continually keep on your radar that, I have to be mindful of that, of that, and of that, or X, Y, Z, whatever it happens to be. When you then get the barrage of emails of, you need to do, you need to do, you need to do. And you're thinking, but I have a day job to do." (LA2, ADP Member)

The second quotation indicates that this ADP member may feel torn between their 'day job' and the demands of the ADP. From this, a key challenge regarding accountability in ADPs emerges: once partners leave the space of the ADP (e.g. leave a meeting of the ADP) their organisation's own priorities and responsibilities are of primary concern, indicating that the work and responsibilities of the ADP as a partnership may be de-prioritised.

Tensions around resources also appeared to be a key source of challenges to partnership working and accountability across this chapter's analysis:

"So the ADP want us to redesign on 20% less [funding] to increase capacity. And I do get to a point where I say, you know guys, not possible. Not possible. Not unless, well, they need to rob Peter to pay Paul, basically, and it gets very divisive because we have quite well established formal and informal partnerships across health, social care and the voluntary sector that have taken a long

time to build up. Before there was any talk of [health and social care] integration...there was well established partnerships sharing of information despite governance issues around data protection and that kind of stuff, we still managed to share information that's required and people get a holistic service you know. But now we're all competing for 20% less, it all gets a lot tetchier again. We've come through a lot of tetchiness, there've been a lot of antipathy between sectors and you know I fear it's all kicking off again because nobody can see how they make 20% less work without that impacting...with no change in policy direction and no change in outcomes... it seems really easy to me for Scottish Government just to say, 'off you go and do this', and they really don't understand that policy into practice doesn't work with that kind of catastrophic change." (LA1, ADP Member, NHS)

Another interviewee described accounting for money spent by the ADP with the intention of progressing on the local Strategy and Delivery Plan. They noted the challenges which arise when partners from statutory organisations (e.g. police, health) are asked to account for their contributions to this progress:

"I think partnership working with statutory services is not particularly great historically, and that's come down to budgets...a massive part of our budget goes to [statutory services], and there doesn't seem to be any sort of – I don't know – governance particularly... [statutory services] just get that money every year. And they just see it as their money, so as an ADP when you're kind of saying, this is our Strategy and Delivery Plan and these are the objectives that we need to make, how are you with that more money helping us with that? The hackles go up and people get quite defensive, and they don't like reporting on that and responding to that, so that's quite difficult and it makes relationships not the best at times" (LA2, ADP Member)

This suggests that although the ADP has an agreed Strategy and Delivery Plan to implement alcohol policy, services and initiatives are often being implemented within the professional context of these statutory organisations, rather than the ADP. Thus it appears that any pressure towards professional accountability between ADP members is often outweighed by each member's sense of accountability back to their own organisation.

Although much of the above analysis is critical of the current system, there were some, more positive reports of shifts towards a growing sense of professional accountability within ADPs. In particular, the role of effective leaders who are strategically placed seemed to be important for increasing effective professional

accountability practices within the ADP. For example, in LA2 a shift among the leadership of the ADP reportedly resulted in ADP subgroups being included more in discussions and, in turn, raising accountability expectations. The quotation from the LA2 member below suggests they perceived this to be a positive shift.

“It's only been fairly recently the [ADP Executive] have been very keen to get the subgroups more involved and to be more accountable as well...Previously, it has been very much, we have subgroups, away doing their own thing, we maybe don't get an awful lot of feedback from them, and now and again we'll ask them some questions about something, or what's being delivered. Certainly, we have to do quarterly reports back into the [ADP Executive] but I've noticed, certainly recently, that there seems to have been a shift in emphasis where we are now included in the [ADP Executive] meetings, and we are expected to provide feedback on whatever we're doing. So, it's about more accountability which I don't think is a bad thing” (LA2, ADP Member)

This echoes public administration literature which observes the leadership roles managers can adopt in an effort to stimulate action within horizontal networks (Wallis and Gregory, 2009). The findings are further aligned with studies in the systematic review, particularly Mooney et al. (2017) who suggest that leadership is an enabler of alcohol policy implementation. Building on their study, my data suggest leadership can play a role in improving accountability relationships within partnerships. Other local interviewees also spoke of the influence that ADP leadership could have on the relationships within, and ethos of, their partnership. Leaders such as ADP Chairs spoke of how they perceived their role as an opportunity to enact positive change in this partnership context, for example by seeking to strengthen the commitment of ADPs to ideas of prevention and recovery-oriented systems of care.

Despite the challenges noted in the data above, a commitment to partnership working was evident among my interviewees. The following quotations from different ADP members in LA2 indicate the importance of partnership for demonstrating the outcomes being achieved.

“All of these things need to be done in partnership, no single, whether it's ADP, or health or social care, nobody should be setting these things on their own. It needs to be partnership considered because they need to be achievable, we need to understand what they mean...we're trying to be clever and we're

trying to develop systems and processes to meet, to help us demonstrate some of these outcomes, but if these things are not marrying up, it can cause quite a bit of confusion, so that would be my caution. These things are great but they need to be done in partnership.” (LA2, ADP Member)

“Where it can be difficult is that understanding of each other's services, and constraints and boundaries that we work within. And that can be very, it can lead to, not a lack of understanding - the good thing about that group is there's not really any conflict of it. But there can be, as we seen yesterday, where communication breaks down. For instance, with alcohol brief interventions in maternity, we don't want to be raising it away up there, to a strategic level. But we may have to, because that means that we won't be able to meet our target. But really, we're relying, then, on one of the agencies at the table to just pick the phone up and speak to us.” (LA2, ADP Member)

There seemed to be a consensus, or a baseline assumption, that working in partnership was the best way to achieve positive outcomes and reach set targets. This assumption existed within the context of constrained finances, and ADP members seemed to perceive that not only was partnership working the best way forward, it may be the only way to achieve their objectives and targets.

A specific benefit of working in partnership, as reported by local interviewees, was that it gave members an opportunity to develop productive, understanding relationships with one another:

“Although it's a large area geographically, it's a relatively small population. So, a lot of the same people sit on a lot of the same committees. And the nice, well the downside of that, is you never met anybody new but the upside of that is, I think, they have quite a lot of influence in a lot of areas. So, they can take work or initiatives and so on, perhaps from one committee, and they can put it in context over all the other work that they do.” (LA3, ADP Member)

“I think [the ADP] does have added value, to be honest, finances aside. I think partners working together is massively important, and I think because it's got some sort of statute if you like behind it, people are very compliant and will turn up to those meetings. Secondly, I think that it's really important because it serves to give a common language amongst partners who work with organisations who have their own organisational language. So, it's very, very easy for people to say, well, I'm doing this because it meets my organisational goals and I'm not doing this because it doesn't. What the ADP does in some of the Quality Principles and the drivers which are new are coming out of the Scottish

Government does, start to say, we all collectively need to be working towards something as a group and understanding that. So, to that end, I think it's useful." (LA3, ADP Member)

This second quotation places the work of the ADP within the broader accountability framework mandated by the Scottish Government (i.e. the mandate to establish ADPs, and to demonstrate adherence to the *Quality Principles*). It identifies that this helps organisations to buy in to the work of the partnership, even if some activities are not directly targeted at meeting their individual organisation's goals.

5.3.3 ADP Participatory (Vertical) Accountability

'Participatory accountability' within Hupe and Hill's (2007) typology is described as the appraisal of policy implementation by citizens or service users, against their own expectations. In the data reported below, interviewees often used the term 'community engagement' to describe aspects of ADPs' relationships with the public⁴². Further, while the data will suggest ADP members are motivated by a sense of responsibility to service users, a similar responsibility to the broader public appears to be somewhat absent (or sometimes conflated with service user engagement). Note, these data are situated within the broader Scottish policy context in which there has been increased discourse around 'community engagement' or 'empowerment' in local governance in Scotland (SCDC, n.d.; Scottish Government, n.d.).

From the outset, my documentary analysis highlighted that while national policy documents and guidance communicate the importance of community engagement by ADPs, they do not tend to explicitly state that this should create an accountability relationship between ADPs and their communities. For example, the *Framework for Action* suggests that community engagement was required only in order to ascertain 'local needs' (Scottish Government, 2009a) and did not elaborate on expectations regarding the relationships between ADPs and the public. A brief section in this policy envisages "working with a wide range of partners to ensure that local delivery of services and activities to tackle alcohol misuse is effective, efficient and

⁴² My interpretation was that most respondents were using 'community engagement' as a catchall-phrase to refer to a spectrum of activities involving the public in local alcohol policy (including, for example, 'consultation' or 'community empowerment'). I report these terms as the respondents use them.

accountable” (Scottish Government, 2009a, p. 25). However, the content that follows does not identify community members, service users or the broader public as parties having authority or capacity to hold to account actors involved in implementing the alcohol strategy.

Somewhat in contrast to the above, the 2015 *Updated Guidance for ADPs* uses slightly stronger language regarding community engagement by ADPs, and conceptualises this as involving service users (but not necessarily the broader public) in planning and decision-making, as well as conducting local needs assessments. Regarding the development of local ADP Delivery Plans, the *Updated Guidance* states in an Annex that:

“[ADPs] should outline in your Plan how service users and carers are/are to be embedded within your partnership commissioning processes and how service users and their families play/will play a central role in evaluating the impact and supporting improvement of your statutory and third sector services.” (COSLA et al., 2015, p. 10)

Additionally, the *Updated Guidance* goes on to simply state that a priority action for ADPs is to “indicate arrangements for strengthening service user engagement” (pg. 12). These excerpts suggest a more formal role for service users and their families to be involved in ADP planning and decision-making, yet their evaluation role appears to be limited to evaluating *services*. It is therefore not entirely clear whether (and if so, how) ADPs should engage in an accountability relationship with service users. However, the quotations also indicate that ADPs can themselves outline in their Plan how they are going to engage with service users, which appears to provide ADPs with some flexibility in enacting this relationship. In other words, ADP members could potentially incorporate accountability into the relationship. The local interview data, which will be discussed below, examines how this relationship has been enacted in the three local areas in this study, and how ADP members often expressed an intrinsic sense of ‘responsibility to’ their respective local communities.

A final observation from the national documentary analysis is that the national documents were not always clear and consistent about who in the community ADPs should engage. For example, as noted, the *Framework for Action* (2009) generally indicated the need to “work with a wide range of partners” (pg. 5). When documents (e.g. the *Quality Principles*, *Updated Guidance for ADPs*) did name a particular

population group, this was most often 'service users' accessing alcohol and drug services and their families or carers. This guidance seems to contrast with the idea of a 'whole population approach' to tackling alcohol-related harm.

Within national-level interview data, there was limited evidence that national stakeholders expected local implementers to be formally accountable to their communities beyond simply involving the public in some capacity (though I acknowledge that interview questions regarding accountability and community engagement were generally asked separately). The statement by the interviewee below is unique among the national-level interviews in indicating that ADPs should actually make changes to their implementation practice on the basis of 'community engagement':

"I think that Alcohol and Drug Partnerships did have a remit to do some local community engagement. And I think that there was an expectation that they would modify their messaging and their techniques accordingly. But, I've said before, they tend to focus on quite narrow segments of the local population." (National Level 4)

Although this quotation recommends a responsiveness of ADPs to community needs, it still does not provide a strong sense of how, or to what extent, local policy implementers ought to be accountable to their communities. Further, this interviewee acknowledges a tension between ADPs' apparent mandate to undertake community engagement to implement Scotland's alcohol strategy (and its whole population approach), while having a remit which focuses their attention on particular segments of the population. Another national-level interviewee commented on the lack of clarity about how ADPs' involvement of service users would be enacted, stating that while there was a "push" from Scottish Government to involve service users in shaping services:

"Bits of the local authority involved in the ADPs would have been far more, insightful and aware of how to do that or experienced in doing it than [Scottish Government] were. It was almost...I mean, I've heard some people say, 'oh yeah, well Scottish Government's just rediscovered community development that had happened 20 years before,' whatever. But that has definitely built [an] expectation from central government, that whole community empowerment and engagement...[It's] not always necessarily terribly clear about what that would look like" (National Level 1)

This quotation is consistent with the observation from the documentary analysis above, that there is a lack of clarity about how ADP relationships with the public are intended to be enacted, including with whom in the public they are intended to engage. It also suggests, however, that local actors may be better positioned than Scottish Government to decide how to enact this relationship.

Local-level interview data provided a sense of how ADP members interpreted national-level expectations (and ambiguity) about community engagement. In particular, local-level interviewees provided a greater sense that ADP members felt an intrinsic sense of responsibility in the course of their work for ‘making a difference’ or ‘improving things’ for their communities and service users:

“[ADP Members] are in public service or they're in voluntary sector because they really want to make a difference to individuals and families and communities.” (LA1, ADP Member)

“if we can identify areas that are needing a wee bit of improvement, we can look at what supports are there to help people move things forward, and ultimately improve things for the folk that are using the services” (LA2, ADP Member)

“most people who end up working with alcohol and drugs, they do it because they believe they can make a difference, so you’ve got a group of committed people.” (LA3, ADP Member)

Further, ADP members described how they sought the feedback of service users and people in recovery in the course of their implementation work:

“We spent probably the best part of 18 months to two years engaging with not just people in recovery but we were really keen to hear their thoughts in terms of what did it feel like to be in recovery from addiction, and what were services were doing or not doing, what was the ADP doing or not doing, what was [LA2] as a whole doing or not doing in terms of supporting recovery?” (LA2, ADP Member)

This interviewee, and others from LA2, indicated that this engagement did inform the ADP’s priorities. Relatedly, another person suggested that, in addition to the ADP and services being responsible for addressing the local community’s needs, community input should inform decision-making on both instrumental and normative grounds:

“I think our services should be designed and reviewed with service user involvement...We need to have services that are relevant to

the needs of the people that we're providing services to. The best way to do that is to involve service users in the planning of these services and the reviewing of them and then getting feedback from them. I mean that's just as a matter of principle. It's just a way I think that services are most effective when they're are designed in that way." (LA2, ADP Member)

This person seems to hold as self-evident that responding to service user needs is a primary task of the ADP, and that this is best achieved by their involvement and evaluation of these services. This was consistent with other local interviewees in also suggesting that ADP members were drawing on normative motivations for involving service user perspectives in their decision-making. Indeed, while the data from the local-level interviews provide evidence that community engagement is occurring within local implementation practices, local interviewees rarely cited policy guidance as their reason for doing so.

Further, it appeared that ADP members' recognition of the importance of responding to service user needs was perceived by them as separate from their accountability obligations back to the Scottish Government (e.g. for achieving national targets). The data also suggested that ADP members' being subject to these different types of accountability created challenges, as they navigated the formal pressures of working towards targets as well as simultaneously responding to service user needs based on their own normative motivations:

"If you go into a community and ask them about indicators, that means nothing to them. What you need to be able to do is take the stuff that they want you to do and take the stuff the people's telling you to do and find the middle ground. Find the middle ground and deliver what people what you to do down here. And they don't need to understand all of that stuff, nor should they about...I'm not being disrespectful with that, but we need to be able to show the government that you're implementing what they want you to do. And that's our job in the middle. Our job's to find that bit to enable people at the ground level to do stuff and feel empowered, but tick the boxes for the government. That's my job." (LA2, ADP Member)

This interviewee described local implementers as occupying a 'middle ground'. Other interviewees, from a range of organisational perspectives, also described a similar drive to ensure that community needs and community-level change was pursued while also meeting national-level requirements:

“We do look at the national policy, and the national drivers, there's got to be a recognition that it's not gonna go away. It probably is under-resourced, it's probably more hidden in a lot of areas, than we really know. And it's up to us, as agencies, to continue to keep that on the front burner, whilst deflecting a lot of the difficult stuff that needs to be doing, and advocating for our client group to show them that there is something at the other end of it.” (LA2, ADP Member, NHS)

“We can do things to tick boxes all day long, and I know we have accountability to Scottish Government and there's funding issues as well, but the way I look at it is we should be delivering projects which are having a meaningful impact on these things, not just to say that we've done something to help to tick a box, something that's hopefully going to have a lasting effect on the communities.” (LA2, ADP Member, Police)

Despite the clear commitment evident in some local interviews to meaningfully addressing local needs, it was apparent that efforts to achieve this were challenging. For example, one interviewee reported they perceived some panic from their partnership colleagues in response to efforts to enact participatory accountability:

“We've developed a service audit tool which aligns itself with the Quality Principles, because that's what we need to be reporting on, and a large part of that will be service user involvement...and my first meeting with statutory services when we looked at the audit tool, there was a panicked look on the face, and 'there's an awful lot of service user questions on here'. Yeah, there is, and that's the way that it should be, because this is what we're wanting people to, we want to know people's experiences” (LA2, ADP Member)

It is notable that I did not have any interviewees say directly that they were resistant to community involvement. However, as introduced in the quotation above, there were a small number of other instances in the data where local level interviewees suggested they had other colleagues who they perceived to be more dismissive of community involvement and participatory accountability. As an example, one interviewee from LA3 expressed frustration with colleagues whom s/he reported were dismissing feedback from service users:

“When I first came here I had this real sort of sense at different meetings I went that there was a real what I would describe [as]... professional snobbery. So 'the experts are right'. And that manifested in one meeting where we were talking and listening to some [service] user voice experience stuff and somebody was quite detrimental to this user experience because they believed their service was performing really well, and they tried to move the

whole meeting on, and that really frustrated me...I said, 'look, you can't just dismiss that, your service maybe is doing a good job, but this particular individual's perception on this particular day is that they weren't treated well, and that is a legitimate voice that needs to be listened to.'" (LA3, ADP Member)

An additional challenge interviewees reported was the potential conflict between participatory and public-administrative accountability, with interviewees suggesting that the former was often de-prioritised in favour of the latter. For example:

"The alcohol project [...] is a case in point. That's not a statutory service. If I'm going to make a choice, which I might have to, next year, about what we continue to provide, service wise, that service might be at risk, because we don't have to do it, whereas we do have to write court reports, we do have to supervise community payback orders." (LA3, ADP Member)

This suggests that the current national level emphasis on formal public-administrative accountability (and relative neglect of participatory accountability) was informing local decision-making in ways that reflected this prioritisation.

The data presented here suggest ADP members often feel a sense of responsibility to service users or the public, and that engaging them is an important component of fulfilling this responsibility. However, the data did not appear to demonstrate that ADPs experienced any formalised mandate to enact a participatory accountability relationship with the public. Further, the data did not provide any evidence that there were formal mechanisms available to members of the public to impose consequences or otherwise exert pressure on the ADP if they judged their decisions to be poor. However, this may be shifting as a result of changes to the legislative context, specifically the introduction of the *Community Empowerment Act (2015)*.




5.4 Discussion

5.4.1 Principal Findings: Reflecting on Hupe and Hill (2007)

This chapter mapped and analysed different accountability relationships experienced by ADP members (their 'accountability regime') to examine how these may influence ADPs' work to implement Scotland's alcohol strategy. While Hupe and Hill's (2007) typology of accountabilities was employed to organise the data, the

results suggested ADPs' accountability regime can be further illuminated by treating these key accountability relationships as 'directional' and top-down or bottom-up in nature: (i) vertical, top-down accountability of ADPs to Scottish Government; (ii) horizontal accountability of ADP members to their colleagues within these partnerships; and (iii) vertical, bottom-up accountability of ADPs to service users / the public (Table 5.2). My analysis of these relationships suggests ADPs' accountability regime is more complex than the Hupe and Hill typology alone allows - they were observed to exist simultaneously to create a complex, sometimes confusing, and context-dependent ADP accountability regime.

Table 5.2 Revised Representation of ADP Accountability Regime

Vertical (top-down) accountability 	Horizontal accountability 		Vertical (bottom-up) accountability 
Public-administrative	Partnership	Professional	Participatory
Scottish Government or Parliament, Care Inspectorate, COSLA	ADP and ADP members	Peers from own organisations	Service users, carers, citizens, residents, etc.

Reflecting on my findings, I have added a column to the revised table to highlight the complexities of the 'partnership' aspects of ADP accountability. While Hupe and Hill's emphasis on professional accountability is clearly reflected in the interview data regarding accountability across partners within an ADP, it fails to capture key aspects of concerns about the ambiguous sense of collective responsibility for the actions of particular actors within the ADP, highlighting the significance of distinctive 'partnership' dynamics as well as professional. Other literature which has used the Hupe and Hill typology in a partnership context, such as van Berkel and colleagues (2010, p. 451), have linked Hupe and Hill's description of intra- and inter-professional cooperation to partnership working but do not explain or justify how they have operationalised this.

In light of the complexity and interconnectedness I observed within ADPs' accountability regime, I felt it was more productive to bring the directional, 'horizontal' terminology of this typology more to the fore here, following other accountability scholars by re-labelling this aspect of ADP accountability as

'horizontal accountability' (e.g. Michels and Meijer, 2008). This labelling refers to accountability where the 'forum' or 'principal' is not hierarchically superior to the 'agent' (Schillemans, 2011). This more accurately captures how (i) ADP members were interacting with each other in horizontal, partnership-based relationships, (ii) how members interacted with the partnership as a whole, and (iii) how these relationships and interactions sat within the context of how the Scottish Government treats ADPs. This modification in how I saw my data in relation to the typology expands from a narrow focus on individual professionals holding their individual peers to account within the same profession (as depicted in the original 2007 Hupe and Hill typology), to a focus on how ADP members try to hold other members to account for their work contributing to the ADP's goals and values.

Finally, where Hupe and Hill (2007) depicted accountability between local implementers and service users as horizontal, I perceived participatory accountability in the relationship between ADPs and service users to be a bottom-up, vertical one. This was because I observed a lack of a formal participatory accountability relationship between these actors - service users do not have a formal evaluative power which would make this relationship more horizontal. It seemed that ADP members were motivated by an intrinsic sense of responsibility, generated from 'bottom-up', towards service users and the broader community.

5.4.2 Principal Findings on ADPs' Accountability Regime, Influence of Context, and Contribution to Literature

This chapter addressed the research question: How was local implementation of Scotland's 2009 alcohol strategy influenced by formal and informal accountability mechanisms in the context of ADPs? The principal findings from the analysis are as follows.

My analysis of the data regarding ADPs' vertical, top-down accountability relationship with the Scottish Government indicated it was characterised by ambiguity and complexity. Firstly, the data suggested the Scottish Government is inconsistent in their communication and actions about whether they are 'supporting' ADPs or holding them to account (e.g. through traditional mechanisms such as reporting and inspection). Second, such ambiguities led ADP members to sometimes speculate what they might be held accountable for (e.g. in relation to

commissioning), which resulted in different actions and variable alcohol policy implementation. Third, this relationship was made more complex by ADPs' status as non-statutory partnerships. The data suggested they were held collectively accountable for realising Scottish Government expectations but their structure often presented a challenge to meeting these expectations, leading to frustration and confusion. For example, ADP interviewees expressed concern that they were held accountable for alcohol policy activities over which they did not have (sole) financial control.

Thus, a second principal finding regarding ADPs' accountability regime was related to horizontal accountability arrangements within ADPs. Namely, that these arrangements are enacted within the context of these partnerships' broader vertical accountability relationship with Scottish Government described above, and bring their own set of challenges for ADPs. Key among these were, despite the mandate that ADPs work in a partnership format, they had not been provided formal guidance about how to operationalise intra-partnership accountability, and this led to a lack of effective horizontal accountability. This challenged progress in implementing the alcohol strategy because not all partners would regularly or adequately report on their actions, leaving the ADP with incomplete information with which to make decisions.

The third principal finding was that while there is not a *formal* bottom-up, vertical accountability between ADP members and the community, ADP members reported being motivated by an intrinsic, or normative, sense of responsibility towards them. This was evident in how ADP members sought to engage service users for the purposes of informing ADP decision-making, and how ADP members sought to respond to their identified needs. Two secondary points are important to make here. ADPs' community engagement was most often undertaken with service users specifically, and ADP members sometimes appeared to conflate 'service users' as a group with the 'community' more broadly. While the focus on service users appeared pragmatic and useful to inform ADP implementation work, it seemed in contrast with the 'whole population approach' of the Scottish alcohol strategy. It implies a narrow sense of participatory accountability focused on service users rather than entailing broader engagement of local communities affected by alcohol. Additionally, while ADP members reported their own prioritisation of

community/service user engagement, when forced to decide between this and fulfilling top-down accountability obligations to Scottish Government, the top-down accountability would necessarily be prioritised. This suggested that these accountabilities were sometimes in conflict with one another, meaning ADPs are unable to prioritise community engagement, despite the Scottish Government's broader rhetoric about the importance of this type of work.

Considering the above findings collectively, ADPs' accountability relationships and associated mechanisms were experienced simultaneously as 'multiple accountabilities', which link together to structure the overall, complex ADP accountability regime. This observation aligns with Hupe and Hill's contention that implementers would, in practice, exist in a "complex institutional web" (Hupe and Hill, 2007, p. 290) and be "confronted with multiple demands for accountable behaviour" (*ibid*). It is only by analysing the 'directions' of accountability relationships, as well as the types and mechanisms, that we can fully understand how such a sense of complexity, confusion and miscommunication around accountability arises within ADPs.

Context and Resources

It is evident across this chapter that aspects of ADPs' context and members' experiences regarding resources influenced their accountabilities and implementation work (for example, see p. 160, 162, 165, 167, 174-175). A specific contextual influence were the budget cuts faced by ADPs at time of data generation. My data make clear that ADP members felt these cuts were strongly influencing their implementation decision-making work and that they perceived the expectation they would continue delivering local alcohol policy at previous levels profoundly problematic. This reinforces the finding in the systematic review (Chapter 3) and broader implementation literature, that resources are a critical factor in implementation work (Casswell et al., 2018; Exworthy and Powell, 2004; Fitzgerald et al., 2015; Foster, 2016; Hill and Hupe, 2014; Matland, 1995; O'Toole, 2004; Parkes et al., 2011). These budget cuts occurred in the broader context of austerity in the UK (Taylor-Gooby and Stoker, 2011) but, perhaps surprisingly, no national interviewees mentioned austerity, and only two local interviewees did (with only one

of these directly linking cuts to the ADP budget)⁴³. Instead, local interviewees seemed to place responsibility for ADP budget cuts with the Scottish Government. This inevitably impacted on the relationship between the Scottish Government and ADPs, with ADP members generally perceiving the Scottish Government to be imposing accountability for alcohol policy implementation while not providing the necessary resources for implementation.

Another obvious contextual factor discussed throughout the chapter was the influence of ADPs' partnership working context, to which funding issues presented further complications. A key finding was that ADPs were being held collectively accountable for activities which they only partially funded (and/or were delivered by a single organisation within the partnership), with members reporting frustration about this. Further, the lack of funding available appeared to foster competition between partners, potentially damaging their ability to collaborate effectively. Together, these results suggest that the funding structures and governance approach to supporting ADPs are currently presenting a challenge to their partnership working and accountability, and thus their overall implementation work. These challenges were evident in the lack of clarity ADP members seemed to have about their responsibilities, and in interviewees' suggestions for how to redistribute their budgets (and accountabilities) in a manner which reflects their status as non-statutory partnerships.

These findings are again consistent with existing literature which recognises the difficulty of working in partnership in a context of constrained resources (Fawcett et al., 2010). For example, in an in-depth report of partnership and alcohol policy implementation, Thom and colleagues (2011) found that "financial constraints/funding", "lack of resources or problems with allocating resources", and "managing cuts often in the face of increasing demands" were the most frequently mentioned weaknesses and challenges of partnerships as identified by local alcohol coordinators (p.26-27). The findings in this chapter and relevant literature consistently point to a continued need for investing sufficiently in alcohol

⁴³ However, one of the included local area's 'Strategy and Delivery Plan' acknowledged that demand for services was increasing at a time of 'economic austerity' – reference withheld to preserve anonymity.

implementation partnerships to support both their partnership and implementation work.

Interestingly, resources were not mentioned in the data as factors shaping ADPs' participatory accountability (although I should note that I did not ask about this specifically in interviews). I can only speculate that, like other implementation activities, community engagement seems likely to have resource-related implications and, therefore, to be shaped by resources

Contribution to Literature

To my knowledge, this is the first analysis of Scottish ADPs' accountability regime. It is useful to place my findings in the context of relevant alcohol policy implementation research and broader literature.

First, ADPs' work to interpret top-down Scottish Government expectations reaffirms findings from the systematic review (Chapter 3) in which the 'translation' work of local alcohol policy implementers often leads to variation in implementation. While the ways accountability relationships are enacted often have elements of subjectivity (Schillemans, 2008), a lack of formal guidance may be exacerbating this variation in Scottish alcohol policy implementation. While such variation is consistent with what is known from existing literature (e.g. Fitzgerald et al., 2017; MacGregor et al., 2013; Parkes et al., 2011), it develops this further by demonstrating variation within accountability relationships between alcohol policy stakeholders.

Second, these findings also add new insight to the findings of the systematic review in terms of 'community engagement'. While the systematic review results found 'public involvement' to be a frequently identified facilitator of local alcohol policy implementation, the research in this chapter represents the first exploration of how and whether local alcohol partnerships in Scotland are being held accountable for their efforts to involve communities and/or respond to their needs. Additionally, none of the included studies in the systematic review differentiated the sets of people within communities with whom alcohol policy implementers may be interacting. This chapter highlights how ADP members are often seeking to engage service users, but that there is less evidence of them proactively engaging the broader public – an approach which is arguably pragmatic and appropriately 'targeted' given their time

and resource availability, however is in contrast with the stated 'whole population approach' of the 2009 alcohol strategy.

Third, as noted in the above subsection on context, this chapter builds on the limited literature which examines partnership working within alcohol policy implementation (Thom et al., 2013a; Thom et al., 2011). Existing research from an English context has noted that tensions can arise between professional cultures within local alcohol partnerships, and calls for a deeper interrogation of how issues of responsibility and accountability may be challenging partnership working (Thom et al., 2013a). This chapter helps confirm Thom and colleagues' (2013a) claim that tensions surrounding accountability to one's own organisation and to the partnership "prevent fully integrated partnership working" (p. 74). My findings help to illuminate and explain these issues in the Scottish context, suggesting that ADP members' accountability to their own organisation is often prioritised over the needs of the partnership. This was potentially exacerbated by the ADPs' status as a non-statutory partnership, which meant that there did not appear to be any meaningful consequences if a member's participation was limited. Further, the findings showed how intra-partnership relationships and accountability between local alcohol policy implementers (from different professional backgrounds) can be a potential barrier to alcohol policy implementation progress.

The finding that horizontal accountability was influenced by the context created by ADPs' vertical accountability relationship with the Scottish Government is consistent with existing accountability literature which discusses horizontal accountability as existing in the "shadow of hierarchy" (Schillemans, 2008). Accountability and governance scholars (e.g. Conteh, 2016; Peters, 2011; Schillemans, 2011, 2008) have argued that the influence of central government is always present (even if not directly applied) in local/decentralised decision-making and actions. For example, this may be through group or partnership members being aware that their "horizontal interactions may have an impact – for better and for worse – in their vertical relations" (Schillemans, 2008, p. 191). In the ADP context, the data suggested ADP intra-partnership relationships and accountability were perceived in relation to the Scottish Government's expectations of them.

In the broadest sense, having analysed that ADPs' accountability regime is often characterised by complexity, confusion, and miscommunication, it appears these findings – from a Scottish public health policy context – align with broader governance literature which highlights that problems can arise when an actor experiences multiple accountabilities that potentially conflict with one another (Koppell, 2005; Schillemans and Bovens, 2011). My findings suggest learning from this literature may be usefully applicable in a Scottish alcohol policy context, where ADPs report conflicts between their formal, top-down accountability to Scottish Government and their normative, bottom-up accountability to service users and the community.

5.4.3 Understanding and Explaining ADP Accountability

The findings in this chapter suggest the top-down accountability relationship between Scottish Government and ADPs is underpinned by Scottish Government's uncertainty about balancing centrally- and locally-held control, discussed above. This in turn seems linked to the way Scottish Government miscommunicates with ADPs and their interpretations of their role. It is therefore understandable that variation in how alcohol policy implementation is enacted locally results from this. Additionally, Government appeared to continue using traditional accountability mechanisms like reporting to keep the partnership collectively accountable. My analysis suggested this use of more singular, traditional, hierarchical accountability mechanisms which treat ADPs as independent entities may be inadequately nuanced and static for effective use within these partnership contexts.

These partnership-related challenges create a context which influences and can help explain the findings generated about horizontal accountability. In particular, the lack of horizontal accountability within ADPs appeared to be linked to the distinction made between statutory and non-statutory organisations, and how statutory ones did not perceive the ADP to be an authoritative, legitimate forum to whom reporting is mandatory. This was plausible given that ADPs are comprised of such a variety of different organisations, each with different backgrounds, professional expectations, and (potentially separate) organisational priorities and accountabilities.

Turning to vertical, bottom-up accountability, the manner in which ADPs prioritise engaging with service users instead of the broader public may be explained by how they reported perceiving service users as being the most relevant population with which to engage. Indeed, the data suggests they perceived service user experiential knowledge as being a key source of information with which to inform ADP decision-making (explored in greater detail in Chapter 7). While this approach to engagement is somewhat in contrast with the 'whole population approach' of the 2009 alcohol strategy, it is unsurprising given ADPs' constrained time and resources to undertake engagement work, and the lack of formal mechanisms or guidance which support them in doing this. Additionally, the language used in ADP guidance suggested ADPs were seen more as service delivery organisations, given that 'service users' and their families/carers were the focus, providing further explanation for why ADPs appear to prioritise their engagement with these particular populations.

The confusion, complexity, and miscommunication which characterises ADPs' accountability regime seems to be explained by a combination of the above factors and the ways in which ADPs are attempting to balance their responsibilities for each of the above accountabilities. For example, local interviewees suggested that ADP members attempted to meet their responsibilities to both central government bodies and to communities (or, at least, service users). Further, that because these pressures were relatively disconnected from one another, ADP members were experiencing both top-down and bottom-up accountability at any given time, creating tensions and challenges. The data suggest these tensions were commonly resolved via decisions to prioritise formal, top-down accountabilities rather than the bottom-up accountability, despite often reporting that they felt the latter was more meaningful. This suggests that ADPs are currently navigating a system which they feel (despite national level statements about 'support') asks them to participate in an 'indicator-oriented' accountability regime (Hupe and Hill, 2007), in which local implementers are overtly and formally concerned with their performance in relation to their superiors, and seek to comply with performance targets. This was happening to such a degree that ADP members claimed top-down accountability and reporting was negatively impacting on their ability to effectively implement Scotland's alcohol strategy, because these efforts were taking time and resources away from meeting community needs. Throughout the data, it appears that these elements have served to muddle accountability and exacerbate implementation challenges.

5.4.4 Implications for policy and practice

Several implications for policy and practice potentially follow from this chapter's findings. First, the ambiguities evident in the ADP-Scottish Government top-down relationship, and the challenges to progressing with alcohol policy implementation which result from this, suggest a need for clear communication between these actors about expectations of ADPs within implementation. Further, any top-down accountability mechanisms need to be cognizant of ADPs' non-statutory partnership structure.

Second, the findings regarding ADPs' current approach to community engagement suggest there may be potential for ADPs to draw on broader policy and legislation to buttress their prioritisation of engagement. For example, the *Community Empowerment Act* (2015) may potentially create more horizontal relationships between ADP members and service users, given that it creates situations in which local public organisations may be held increasingly accountable for demonstrating how they involve the local community in their work (SCDC, 2015). Note, however, it is unclear whether this would extend beyond service users in ways that reflect the whole population approach of the alcohol strategy.

Third, ADP members were clear about the need to have commensurate resources and authority to meet the expectations placed upon them. As noted above, the accountability expectations experienced by ADP members appear to be currently imbalanced compared with the resources they have available. Rethinking may be required to find more reasonable balance between these, although this will be challenging in a context in which the need for alcohol services remains high (Audit Scotland, 2019).

5.5 Conclusion

This chapter demonstrated that ADPs report experiencing an accountability 'regime' characterised by confusion, complexity, and miscommunication between themselves and those to whom they feel formally or informally accountable to. In their experiences of this accountability regime, ADPs report multiple accountabilities, which are experienced simultaneously, sometimes resulting in tensions.

This chapter made a number of contributions to alcohol policy implementation scholarship. First, it showed how Hupe and Hill's (2007) framework can be usefully adapted in terms of rethinking the idea of 'professional accountability' within a partnership working, alcohol policy implementation context. Second, the analysis represents the first time research has mapped and analysed the accountability regime of Scottish ADPs and how this may influence their work to implement locally Scottish alcohol policy, including considering how their accountabilities overlap and potentially conflict. Third, it built upon what is known about alcohol partnerships in the context of alcohol policy implementation, and more explicitly interrogated the accountability challenges surrounding these partnerships.

6 “You’ve got to weigh up different things”: Accountability and Licensing Boards in Scotland

6.1 Introduction

This chapter examines how LBs, as public organisations that exist beyond the traditional health arena, can have important impacts on implementation processes and subsequent health policy outcomes. In doing so, this chapter addresses the specific research question: “How was local implementation of Scotland’s 2009 alcohol strategy influenced by formal and informal accountability mechanisms in the contexts of Licensing Boards?”

This chapter presents data and analysis which have been published as a research article in the *International Journal of Environmental Research and Public Health* (Wright, 2019 - see Appendix 14). For thesis submission, this chapter elaborates and expands on this already published material.

As described in Chapter 2, LBs are constituted of elected local Councillors, who, barring an appeal process in court, are the sole decision-makers about whether an alcohol licence is granted to an individual or premises. The formal roles of other alcohol policy implementation stakeholders, such as members of the local Health Board, or Police⁴⁴, are as ‘consultees’ to the LB, which means they can officially ‘object’ to a premises being granted a licence and present evidence to support their objection, but are not licensing decision-makers. Further, LBs are quasi-judicial committees, which means their decisions can only be challenged in a Sheriff’s court (MacGregor et al., 2013); this distinguishes them from other local political committees which have corresponding ‘scrutiny’ functions (Cllr L Young, 2018, personal communication, 6 May). Finally, local Councils and their respective Councillors are relatively autonomous from the Scottish Government – this relationship is governed by a Concordat between them, but the important note here

⁴⁴ Members of the Health Board and police service are also members of local ADPs, however their status as consultees to Licensing Boards are a separate aspect of their organizational role.

is that Councillors on LBs are consequently not automatically obliged to follow the priorities of the Scottish Government.

This chapter is situated within and looks to build upon existing alcohol policy literature. First, it takes as its point of departure that LBs are responsible for contributing to alcohol policy implementation and its intended public health outcomes. This reflects existing research linking alcohol availability and alcohol-related harm (Alcohol Focus Scotland, 2018; Richardson et al., 2015, 2014; Stockwell and Gruenewald, 2004). Second, it follows clear indications from the Scottish Government that LBs are intended to be key stakeholders in the implementation of Scotland's whole population approach to alcohol (and its public health goals). These include statements within the *Framework for Action* and related guidance which identify reduced availability of alcohol as linked to the achievement of reduced alcohol-related harms (Scottish Government, 2009a). This link is most explicitly established through the public health licensing objective within the *Licensing (Scotland) Act 2005*. As has been noted (Chapter 2), Scotland is unique in the UK context for including the protection of public health as a statutory objective in its licensing legislation. This objective gives LBs a duty to assess the number and density of licensed premises in their area, which is operationalised in the concept of 'overprovision' (MacGregor et al., 2013).

While existing research contributes to understanding about licensing processes, there remains a limited body of empirical research in the UK and Scottish contexts reporting how key stakeholders are being held accountable for their role in effectively implementing licensing policy, or how the accountability regime(s) surrounding licensing influence alcohol policy implementation. Indeed, recent work by Fitzgerald and colleagues (2018) is unique in its inclusion of accountability as a sub-theme in their analysis of democracy and power in Scottish licensing. Their research reported a lack of mechanisms available to influence Councillors who were members of local LBs, and that LB convenors and licensing clerks had power to shape a given LB's attitude towards public health. This situation sometimes resulted in challenges to public health progress locally and variation across local areas in terms of how the public health objective was perceived and implemented. This chapter helps to build upon and complement those authors' work. For instance, where Fitzgerald and colleagues (2018) interviewed 13 public health actors and

covered 20 LB areas in Scotland, this chapter draws on interviews with both health and non-health actors - including LB members' themselves – and focuses on deeply exploring interviewees' experiences in only three local areas. Further, Fitzgerald and colleagues' stated aim was to explore distributions and manifestations of power within licensing processes – it is with this explicit interest in mind that they briefly turned to accountability. This current chapter is exclusively focused on the issue of LB accountability, seeking to understand and map formal and informal accountabilities of LBs, and thus provides an in-depth, nuanced account of this issue in relation to Scottish alcohol policy implementation.

More broadly, in-depth inquiries specifically into accountability remain limited in existing alcohol policy implementation literature, and findings are not linked to accountability literature, a substantive area of research from which theoretical and empirical lessons may be drawn (see Chapter 3). Alcohol policy implementation studies have sometimes discussed accountability-related issues including the importance of clearly establishing responsibility for particular interventions (Fitzgerald et al., 2015), or policy stakeholders' compliance with relevant alcohol legislation (Herring et al., 2008; MacGregor et al., 2013). Despite this, a notable gap in published research exists which draws explicitly upon lessons from accountability scholarship to empirically examine alcohol policy implementation. This chapter seeks to contribute understanding to this gap. It will do this by examining, mapping and analysing different accountability relationships experienced by local licensing decision-makers in Scotland.

The structure of this chapter is as follows. First, the empirical results will present a detailed account of LBs' accountabilities, as reported in both the national and local interview data and gleaned from national policy documents. Similar to the previous chapter (Chapter 5), the typology of public-administrative, professional, and participatory accountability from Hupe and Hill (2007) will be utilised to organise the results. This typology is again useful to shed light on different types of accountability LBs may experience. However, given that LBs are not structured as 'partnerships', the modification I made to the typology in the previous chapter to incorporate consideration of partnerships will not be utilised here. The second main section of the chapter will present an in-depth discussion of these data in order to explain that LBs' accountability regime is characterised by a dependency on legal accountability,

and a relative absence of other public-administrative, professional, and participatory accountabilities. It will be argued that there is a gap between the intentions of licensing legislation with respect to public health and the way it is enacted in practice.

6.2 Public-Administrative Accountability of Licensing Boards

6.2.1 Perspectives on the Licensing Objectives and the importance of accountability: Policy context of alcohol licensing

My analysis of LBs' public-administrative accountability first acknowledges how Scottish Government reportedly conceptualised LBs' contribution to implementing the alcohol strategy, namely by helping to reduce alcohol availability and related harm. Multiple national level interviewees involved in developing the Scottish Government's *Framework for Action* reported that they consciously considered the link between availability and harm during the development of this policy. For example, one interviewee spoke about using the concept of availability as a key component of the Government's new, whole population approach to alcohol:

"If you're thinking about a policy or a strategy you've got to have interventions at all...levels, and that price and availability fits in that wider society, that population level intervention. So we were sort of reframing, if you like, alcohol as not just being an individual choice thing, and it also wasn't just about the high risk drinkers at one end of the spectrum, that those are the ones to target. That's very much the industry framing. So we were shifting it." (National Level 6)

It was in the context of such a perspective that LB members and other licensing interviewees discussed the licensing objectives. Of particular importance is how they contrasted the public health objective with the priority afforded to the other objectives, suggesting that the public health objective had not yet led to major changes in how licensing actors operated:

"I think [the public health objective] has always been the poor cousin of the five licensing objectives. It's a difficult one for the Board to deal with, because an application where there are issues of disorder, or public nuisance, noise, whatever, in an immediate area, that's quite clear... and the police might provide evidence to that effect...they can tie in a refusal with the kind of disorder and public nuisance licensing objectives. Public health has always been more of a difficult one for the Board... the Board doesn't

really see favour with overprovision as a concept” (LA1, job title withheld)

“...[the public health objective] doesn’t have teeth at the moment...there are very few of my colleagues on the Licensing Board that would be happy to argue for the refusal of a licence based purely on that licensing objective. You’ve got to try and find something else as well. You’ve got to find overprovision or you’ve got to find local knowledge or you’ve got to find something else to turn a licence down. You can’t do it just on the basis of that objective. That’s the perception anyway.” (LA1, Licensing Board Member)

In relation to this, the interview data suggested that an analysis of LB accountability may help explain some of the problems associated with implementing the public health objective, and the role of licensing in pursuing Scotland’s public health goals more generally. For example, one interviewee reported on frustrations being raised across local statutory alcohol policy implementation actors in relation to the lack of accountability surrounding LBs:

“[we were]...working with the police and the NHS, to try to influence the Licensing Board, nothing really happening, and then that frustration coming back at the Community Planning Partnership level because they can’t influence it either. So yeah, Licensing Boards, because of legislation, are sitting out here doing as they please without any accountability.” (LA1, ADP Member)

It is against this backdrop that the rest of this section’s analysis is presented.

6.2.2 Legal Accountability of Licensing Boards

Existing legislation and regulation for LBs outlines the relevant provisions regarding accountability of LBs. Table 6.1 provides the legislative accountability context for LBs, however the data suggest LBs have certain flexibility within it, which has implications for how they contribute to the public health-related aspects of the legislation, and Scotland’s whole population approach overall.

Table 6.1 Legislative provisions regarding Licensing Board accountability

Legislation	Relevant provisions regarding accountability of Licensing Boards
Licensing (Scotland) Act 2005	<ul style="list-style-type: none"> • Mandates that LBs produce a Licensing Policy Statement once every three years, which provides a locally-specific legal basis for their decision-making. • Mandates that the Licensing Statement include statement on whether local areas are overprovided for (enacted 2009). • Outlines the five licensing objectives, including protecting and improving public health.
Alcohol etc. (Scotland) Act 2010	<ul style="list-style-type: none"> • Makes modifications to mandatory conditions of premises and occasional licences which were in 2005 Act. • Sets out actions Licensing Board must undertake before and after it makes a variation to premises licence conditions, and states a variation to licence conditions may be made only where the Board is satisfied that the variation is necessary or expedient for the purposes of any of the licensing objectives. • Amends the 2005 Act to add the relevant Health Board to the bodies the Licensing Board is required to consult when developing their Licensing Policy Statement, and to notify the Health Board of any premises licence applications.
Criminal Justice and Licensing (Scotland) Act 2010	<ul style="list-style-type: none"> • Makes modifications to 2005 Act regarding application notification requirements, occasional licenses, hours, etc.
Air Weapons and Licensing (Scotland) Act 2014	<ul style="list-style-type: none"> • Mandates Licensing Boards submit annual reports of functions to Scottish Government, which must include a statement explaining how the Board has had regard to the licensing objectives and their Licensing Policy Statement

An example of this flexibility is in their development of overprovision statements. The *Licensing (Scotland) Act 2005* has accompanying *Guidance for Licensing Boards and Local Authorities*, which notes that LBs are meant to make an “accurate assessment of overprovision” (Scottish Executive, 2007). However, the *Guidance* does not specify what an ‘accurate’ assessment was to entail. The only existing legal stipulation is that LBs must demonstrate they have considered the number and capacity of licensed premises in the area and have conducted certain mandatory consultations with, for example, statutory services and the public. However, the number and capacity at which an area should be designated as overprovided is determined by the LB itself – there is not a uniform threshold against which areas are measured, nor is there a national ‘example’ or template overprovision statement from which LBs can draw (MacNaughton and Gillan, 2011). Accordingly, LBs act autonomously to interpret availability-related evidence and establish local thresholds for overprovision as they see fit. In this context, ADP members reported their frustration in attempting to inform LB decisions regarding their Policy Statement and overprovision. For example, one interviewee described working with other local

licensing stakeholders to provide an evidence-informed report to the LB, which recommended certain local areas be labelled 'overprovided', noting that this was unsuccessful given the autonomy LB members had to make the final decision. The issue of LB interpretations and uses of evidence, and the tensions created with how ADPs use evidence to progress public health goals, will be discussed further in Chapter 7.

The interview data also illustrated that members of LBs recognised, and consciously used, their existing discretion within the legislative framework. Some LB members spoke about their consideration of the relevant legislation:

"So we do implement the policy, but the policy is always open to interpretation" (LB Member, LA1)

"The licensing laws...they keep everybody tight on what way we should be going or what we can do or can't do or if we've got leeway in a certain place." (LA3, LB Member)

The second interviewee quoted above made this statement while explaining how the LB had decided to change a local policy about licensed premise curfews. S/he explained that such decisions must be reviewed by legal personnel to ensure that they are aligned with, or are 'tight on', national legislation, but that in this instance, the LB had the discretion, or 'leeway', to make a decision regarding curfews. There are specific personnel who help LBs to navigate the licensing legislation - legally qualified Clerks, which are mentioned throughout the *Licensing etc. (Scotland) Act 2005* (Scottish Parliament, 2005). A similar, institutional support mechanism does not exist for other aspects of LB's public-administrative accountability, an early indication of the dominance of legal accountability in the overall set of LB accountability arrangements.

The flexibility within the licensing legislative framework seems to have been intentional on the part of legislators and civil servants. For example, in the cover letter of the associated *Guidance for Licensing Boards*, the Scottish Government states:

"...would like to stress that Boards will have the flexibility to operate and take decisions in light of their particular circumstances...That is a fundamental principle of the [Licensing] Act and it is important to maintain it. The guidance does not seek

to instruct Boards exactly how to make the Act work.” (Scottish Executive, 2007)

This purposeful flexibility seems to help LBs maintain substantive autonomy to interpret and implement the legislation. An implication of this, however, is that although this may allow LBs to contextualise the legislation (‘in light of their particular circumstances’), this also leaves them free to interpret the licensing objectives flexibly, or even ignore the ‘spirit’ of the legislation which seeks from LB members an understanding and concern about public health impacts of availability. The findings from this research suggest this flexibility has contributed to the limited implementation of the public health objective. For example, as will be discussed below, LB members appear to often prioritise local economic concerns (which are not enshrined in a licensing objective), presenting a potential challenge to the pursuit of public health goals.

When asked what consequences would be applied if LBs were to diverge from their legal responsibilities, interview responses suggested that the primary fear was licensing decisions being appealed in court by the licence applicant, and that the cost of this would be significant.

“Well the Board’s accountable. I mean, it’s accountable by the reason that if it makes the wrong decisions, it ends up in court...and costs the council, you know, £50,000, £70,000, £100,000 in the court case.” (LA3, LB Member)

By ‘wrong decision’, this interviewee appeared to be referring to a decision which can be legally challenged because it is/appears to be in error of the law or against the LB’s Licensing Policy Statement. They also seem to have internalised a belief that being taken to court about a given decision indicates that it was therefore the ‘wrong’ one.

This legal challenge is the clearest mechanism of LB accountability (i.e. an LB may face consequences for their decisions) that was generated from the research findings. In this instance, a licence applicant (e.g. supermarket chain, restaurant, etc.) or a licence holder (whose licence has been varied, suspended, or revoked)

can appeal to the Sheriff Court, a civil court in Scotland⁴⁵. In this system, LBs are held to account by the court as an organisation. This type of legal accountability is an important mechanism which can prevent the abuse of public powers and which operates largely independently from the political process (Bovens, 2010).

If a licence applicant or holder wishes to trigger an appeal of Board decision, they can do so within 21 days (Scottish Courts and Tribunals, n.d.). The grounds for appeal can include that the LB erred in law, based their decision on incorrect facts, acted contrary to natural justice, or used their discretion in an unreasonable manner. In contrast, 'objectors' to an application (who may, for example, be a statutory consultee like the police/NHS or members of the public) are not able to appeal a decision (Alcohol Focus Scotland, 2016a). Therefore, the same routes for triggering legal accountability mechanisms do not exist for objectors, constituting an inbuilt imbalance between the powers of licence applicants and alcohol policy implementers. Additionally, given the costs associated with mounting legal challenges, this system favours those with greater financial resources, and it seemed evident, from the interview data, that this informed members' sense of where challenges were likely to originate from (and where not). For example:

"I think the Board...has a lot of responsibility and a lot of authority that's pretty much unchallenged unless you can afford to go to a Sheriff to overturn a decision. I mean if...we refuse alcohol in a BP [formerly 'British Petroleum Company'] service station, BP will take us to court...But, small retailers won't, it's just not worth it" (LA1, LB Member)

"again it's that independence, the Board's quasi-judicial so whatever we decide can only be overturned by a sheriff or a judge making that, and apart from some of the big corporate companies, most people are not going to go to the expense of engaging a sheriff to say, "I want that to change". So your decision's pretty much final." (LA1, LB Member)

The findings suggest that this LB flexibility has contributed to the limited implementation of the public health objective.

⁴⁵ A Sheriff Court is where the majority of civil court cases in Scotland are heard and is a lower court in the Scottish courts hierarchy, sitting below the Court of Session and the UK Supreme Court (Scottish Courts and Tribunals, n.d.).

Flexibility Helps Permit Prioritisation of Economic Considerations Over Protecting and Improving Public Health

The flexibility of LBs to interpret legislation discussed above was also evident in interview data about local economic concerns. The way economic considerations and public health can come into conflict within Scottish alcohol policy has been noted in the existing literature (e.g. Fitzgerald et al., 2017), which this research complements by adopting an accountability perspective.

Multiple LB members discussed the need for licensed premises to contribute to employment and the economy, despite the absence of the economy being a consideration in the licensing objectives. For example:

“A lot of places...they need their licensing outlets...it’s job provision. It’s like having a factory, you know...so that’s the way you’ve got to look at it” (LA3, LB Member)

This type of response indicates that LB members’ interpretations of the licensing legislation and objectives is flexible enough that they can take into consideration the (local) economy, even if this leads them to make decisions that go against the stated licensing objectives and increase the availability of alcohol in a given area.

“The third pub’s open for the tourists. So that then brings in tourism and it brings in employment...you’ve got to weigh up the different things.” (LA3, LB Member)

This quotation was provided by a LB member concerned with the economic wellbeing of their local area, which they perceived as being dependent on tourism. Other LB interviewees displayed similar concerns, that the anticipated money and jobs that licensed premises might provide were considerations when they decided on a licensing application. However, LBs have a formal, legislative-determined responsibility for progress towards the public health objective and no formal responsibility for being concerned with the economy, and yet the concerns of members seem to be often focused on the latter.

The tension between LB prioritisation of the economy and public health was explicitly discussed by one LB member, as shown in the quotation below. However, this interviewee’s perspective that public health should be of greater consideration

was a minority voice among LB interviewees (only two of the eight LB interviewees expressed this viewpoint explicitly).

“I’m aware that other Board members have conversations about the economic impact of their decisions. Now obviously under the [Licensing] Act they’re not supposed to take that into account at all and I certainly try not to when I’m making decisions but I know that other Board members do and I’ve been told for example in the members’ lounge, ‘well, if that supermarket wasn’t going to set up there then it would just be another empty unit for years to come and they’re providing jobs anyway so why on earth are you standing in their way?’ I think that’s a somewhat short-sighted approach and doesn’t take into account a fair bit of evidence that suggests that adding another off-licence in an area that’s already over provided for is just likely to make problems with alcohol, and overconsumption of alcohol worse.” (LA1, LB Member)

Recognition of this was also evident in a national level interview:

“[Licensing Boards] sit outside that local accountability. And I suppose the tension between the licensing objectives and what they see as their economic objective now licensing doesn’t have an economic objective that it has for five licensing objectives, but they still see themselves as having an economic objective, and that probably provides quite a lot of tension.” (National Level 3)

This quotation suggests that some LB members have adopted a sense of accountability for pursuing economic objectives relating to perceived local needs and that this is felt more strongly than their obligation towards the licensing objectives, despite the legal framework attached to the objectives. It also suggests that this approach will be maintained as long as LBs are excluded from other local accountability structures. The problem with this tension is that, from the perspective of other local implementers, it challenges their efforts to implement the 2009 alcohol strategy and achieve its goals of reducing alcohol-related harm in the Scottish population:

“unfortunately a lot of our objections haven’t met with much success, and the Board have granted applications that we’ve objected to...sometimes [licence applicants’] lawyers quote economic reasons, employment, and all of those reasons, whilst it might be a factor in the decision-making, it shouldn’t really be because they should be basing decisions on the licensing objectives and the legislation.” (LA1, Police Representative)

The police are a statutory consultee on every license application, and thus can file formal objections to any application. In the above quotation, a police representative

suggests that LB members have made licensing decisions based on information surrounding the economy or employment. These are not only unsupported legal grounds for licensing decision-making but may also come into direct tension with the licensing objectives and legislation (and existing public health research). Further, this person seems to suggest that these economic reasons are used by the LB to overrule local statutory objections to applications. This means that economic considerations may be a threat to this mechanism by which local statutory actors can attempt to influence the restriction of alcohol licences. This is despite the existing *Guidance for Licensing Boards* (2007) stating,

“Commercial considerations are irrelevant to a policy which is designed to protect the wider public interest” (p.19)

While formal guidance for policy action separates commercial considerations and public interest, it appears that the level of flexibility allowed to LBs within their legal accountability arrangements has created space for economic considerations to push aside public health concerns.

6.2.3 *Lack of Public-Administrative Accountability to Scottish Government*

Data from documents and interviews generated understanding regarding LB accountability in relation to the Scottish Government. In the Government's *Framework for Action*, LBs are mentioned multiple times as contributors to reducing alcohol-related harm in Scotland (Scottish Government, 2009a). However, the language around holding LBs to account for these contributions is restrained. For example, the *Framework for Action* states, “we will *encourage* local Licensing Boards to develop local solutions to address local problems.” (Scottish Government, 2009a, p. 14 emphasis added). This inscribed language suggests that the Government recognises and perpetuates the autonomy of LBs, indicating in its communications that it must request, not demand, their cooperation in the whole population approach to reducing alcohol-related harm (a point also underlined by the cover letter to LB guidance discussed earlier (Scottish Executive, 2007)). National-level interview data also suggested the Government was clear that LBs were not accountable to them:

“Licensing boards aren't accountable to Scottish Government. So we were not performance managing this across the whole system.” (National Level 4)

This view of the consequences of the system's accountability arrangements seem to have been clearly communicated to local level - LB members consistently indicated that they were not accountable to the Scottish Government. Further, LB interviewees reported that they did not perceive Scottish Government to be actively monitoring their decisions or actions. What is notable here is the tension between the Scottish Government's role in leading Scotland's approach to tackling alcohol related harm, and the inability to hold a key set of organisations to account for contributing to (or undermining) this effort. If the Scottish Government is providing the mandate to pursue public health goals through the implementation of their alcohol strategy, but cannot hold LBs to account for their role in this, then it seems likely that LBs will continue to prioritise other concerns. As an example, the LB interviewee quoted below argues that the purpose of a national policy is nullified if LBs can simply ignore it.

"you can have a national policy up here, but if the Board's just ignoring it, I'm not suggesting the Board is ignoring it, but we might sometimes ignore it, what will you do about it? You know I don't think there's any accountability to the Scottish Government to say, 'so you can sit and make a big document to sit on the shelf all you want, but we'll just ignore it'. And what are you going to do about it. So, I'm not sure there's any point in having a national policy document if Licensing Boards can just make their own minds up."
(LA1, LB Member)

A tension between LB members' roles as Board members and as local Councillors is evident. The Scottish Government has implemented legislation that places Councillors on quasi-judicial Boards, but has not developed a corresponding system to hold them accountable for their actions on it. Further, it may be difficult for the Scottish Government to enact a new approach to accountability over Councillors because, one could speculate, Councillors could perceive such actions to undermine local democracy. These results demonstrate that this particular mismatch in LB accountability constitutes a barrier to full implementation of Scotland's 2009 alcohol strategy because it means LBs' responsibility for contributing to public health goals are not enforced by existing governance structures.

Additionally, this lack of LB accountability to the Scottish Government further distinguishes LBs from other alcohol policy implementers such as ADPs. For example, the *Framework for Action* is stronger surrounding the responsibilities of

ADPs, including phrases such as “we *expect* decisions...” (Scottish Government, 2009a emphasis added) when discussing the roles of ADPs. This suggests the Scottish Government feels differently (and less strongly) about the accountability of LBs to the government in comparison with ADPs. Overall, it appears there are important differences between LBs and other alcohol policy implementers (i.e. ADPs) in terms of their accountability relationships with the Scottish Government. Further, these differences seem to stem from a failure to make an important change that was needed to accompany the introduction of public health as a licensing objective to facilitate implementation. This is important because it reveals the variation in accountability arrangements across different implementation stakeholders, which may have implications for implementation processes.

6.2.4 Criticism of Lack of Accountability to Scottish Government

Within the interview data, critiques of current public-administrative accountability for licensing were clearly evident. It was notable that some LB members were critical of their own accountability arrangements and advocated greater consideration of public health outcomes by their LB. For example, two LB members from LA1 were particularly critical of current LB governance and accountability throughout their interviews. The quotation below discusses an LB member’s issues with how their Policy Statement was developed (a process which is conducted mostly in private⁴⁶).

“[The Licensing Board]’s not very accountable and it’s not very transparent [...] I have no great problem with people making decisions that I disagree with but I do think they should be accountable for those decisions and at the moment they aren’t entirely” (LA1, LB Member)

This quotation speaks to the issue of LB governance and transparency as it relates to accountability. It also raises the issue that if an individual or organisation *wanted* to hold the LB to account for the final content it puts in its Policy Statement, it might be difficult to do so. The quotation below also demonstrates this:

“We pretty much make our own minds up, and that’s final. I mean [licence applicants] can appeal the decision in the Sheriff court but other than that there’s no way to appeal to, to anyone [...] So, not

⁴⁶ The Policy Statement is developed by an LB in private, then sent for public consultation and review by the LB’s legal team. Final decisions about the content of the Policy Statement are made in private, without further public input following consultation.

to sound big-headed in any way, but I don't think there is a huge feeling of accountability from Board Members to anyone in particular." (LA1, LB Member)

This quotation also illustrates the relative lack of checks and balances that influence LBs (with the exception of appeals). In their interview, the LB member quoted above is critical of this situation, perceiving that the LB can simply ignore national policy and makes decisions about the development of their Policy Statement unchecked.

6.2.5 Lack of Public-Administrative Accountability to Local Governance Hierarchy

Moving on to an analysis of LBs' public-administrative accountability within local-level governance, findings demonstrate Boards sit beyond local accountability regimes and lack local-level accountability.

"[The Board] has nothing to do with the other council structures. It's a body on its own. It's not accountable to anybody else in the council." (LA2, LB Member)

The above quotation is indicative of the consensus among interviewees that, at an organisation-level, the LB is not accountable to the local council – it sits independently from the usual local accountability regime for local Council committees.

Local and national level alcohol policy interviewees were critical of the lack of accountability of LBs to local governance bodies. In particular, there was recognition and frustration surrounding the inability of local public sector actors such as members of Community Planning Partnerships or other health and social care representatives to hold LBs to account for work which affected other local organisations.

"lots of activity at my level...working with the police and the NHS, to try to influence the Licensing Board, nothing really happening, and then that frustration coming back at the Community Planning Partnership level because they can't influence it either. So yeah, Licensing Boards, because of legislation, are sitting out here doing as they please without any accountability." (LA1, ADP Member)

Frustration was also expressed by national level stakeholders:

“health is now one of the objectives of the licensing system and health partners are statutory consultees. But that’s quite tricky...you’ve got locally elected members who sit on Licensing Boards, but the Licensing Board isn’t part of community planning...so you can have a Community Planning Partnership that says, alcohol’s a priority for us and then you’ve got a local Licensing Board that basically says, who cares? You know, nothing to do with us, guv...so you’re ignoring the whole evidence base and there’s no accountability.” (National Level 1)

This lack of accountability creates a barrier for effective achievement of alcohol policy goals, specifically the reduction of alcohol-related harm through the restriction of availability. The above quotation illustrates that interviewees generally felt LBs could essentially ignore the goals and priorities of other local government entities, even when these priorities were directly related to LB decision-making about alcohol licenses (e.g. health as a licensing objective, and alcohol problems as a community planning priority). It also suggests that public health evidence has a limited impact in this context. This is problematic because it has the potential to create a tension between LBs and other alcohol policy implementers (an issue discussed in greater depth in Chapter 7).

6.2.6 Recent Changes to Licensing Board Accountability: Continued need for accountability considerations

More recent legislation makes amendments to the existing regulatory regime surrounding LBs, which may have implications for their accountability. Specifically, the *Air Weapons and Licensing (Scotland) Act 2015* builds upon the expectations of LBs by mandating they publish annual reports on their functions. The *Air Weapons and Licensing (Scotland) Act 2015* was developed following a 2012 consultation surrounding two main themes: “strengthening the powers” of LBs and Police Scotland; and improving the “effectiveness of the licensing regime” (Scottish Government, 2012, p. 3). It also introduced a mandate for LBs to report annually to the Scottish Government. Therefore, one might hypothesize that accountability of LBs to the Scottish Government may change with more comprehensive enactment of the Act, although my interviewees did not express any expectations of this when I interviewed them in 2015/16.

A key component of the *Air Weapons and Licensing (Scotland) Act 2015* is the requirement of LBs to begin submitting annual reports of their ‘functions’ (Scottish

Parliament, 2015c). In interviews, a Deputy Clerk for a LB was optimistic that this would enhance the accountability of LBs:

“you can have several months' worth of [Licensing Board] business going by without much awareness, outside, of what's going on. And I think annual reporting, with specific information about the financial, you know, details of the annual fees coming in, details of what the fees are being used for, details of the numbers of applications, all of that. I mean, I don't know, I think we'll find out in due course, by way of regulation, what those annual reports will have to contain. But I think it's a good thing.” (Deputy Clerk to a LB)⁴⁷

The *Air Weapons and Licensing (Scotland) Act 2015* (s.56 (2) (2)) requires that the annual functions report include statements regarding how the LB has had regard to the licensing objectives and their Policy Statement, as well as a summary about their decisions and the number of licenses in their area. However, although this section of the legislation was enacted in 2017, meaning the first reports began to be submitted in June 2018, the format and specific content of LB annual reports have not yet been published by Government (Scottish Parliament, 2017)⁴⁸.

Additionally, language in the legislation suggests that these requirements will have the same flexibilities as observed with other licensing legislation. For example, the Act states:

“A report under this section may include such other information about the exercise of the Licensing Board's functions under this Act as *the Board considers appropriate*.” (s.56 (2) (3), emphasis added)

This type of language suggests LBs will again be given autonomy in how they participate in this accountability reporting exercise, even the type of information they wish to submit for scrutiny. In light of Bovens' definition of accountability

⁴⁷ The local area number is not provided to ensure the Deputy Clerk's anonymity

⁴⁸ The corresponding annual financial reports were first produced by LBs for the year 2016-2017, and initial assessments by AFS suggest they vary in their level of detail, suggesting similar variation in quality of reporting for functions reports can be anticipated (G Crompton 2018, personal communication, 8 May). At time of writing, no formal guidance has yet been issued to LBs. A consultation regarding updated guidance for LBs was held in 2019 (Scottish Government, 2019b); at time of writing the Alcohol Policy Team at Scottish Government is analysing the consultation and the revised guidance will include mention of the Air Weapons and Licensing Act and the corresponding annual functions report (A. Ferguson, 2020, personal communication, 13 February).

underpinning this analysis (Bovens, 2010, 2007) this type of statement, in which the potential 'actor' may use discretion to select what information they provide to a 'forum' (and thus what they have to explain/justify), may undermine the possibility of establishing a robust accountability relationship between LBs and the Scottish Government.

Although the Deputy Clerk above was positive about this anticipated change, when asked about this upcoming obligation, LB interviewees expressed some scepticism about the extent it would make a difference to accountability. For example:

“It should have an effect. I don't know if it will...it's just unfortunately I think some individuals will stick to their guns regardless.” (LA1, LB Member)

Additionally, multiple LB interviewees stated that they either had not studied the 2015 legislation yet (and needed to be reminded of how it included the annual reporting obligation) or had only heard of it recently in a brief meeting discussion (despite these interviews having been conducted in late 2016). These findings could suggest that the stakeholders in the licensing system do not perceive the reports to be an important activity, or that its impact on licensing has not yet been well communicated. Overall, interviews with LB members indicated that the legislative changes were not yet implemented at the time of the interviews and did not suggest that there was any urgency to do so.

6.3 Professional Accountability of Licensing Boards

6.3.1 Professional Accountability of Licensing Board Members to Political Party

Professional accountability is concerned with accountability to one's professional peers (Hupe and Hill, 2007). It is operationalised in this research as including a range of potential professional relationships; it is not restricted to, for example, accountability of a professional to their respective national association (e.g. a physician to their college). To examine professional accountability within LBs, the members selected for interview represented different political parties, with diversity among them in terms of their political views/affiliations and professional backgrounds.

In terms of their accountability relationships at this level, LB members reported not feeling accountable to their political party for LB decisions, and this was reaffirmed by non-LB interviewees. For example, there is no mechanism by which political parties hold their members to account for decision-making in this forum:

“the Licensing Board is not political, so it's not whipped, so you don't have to vote with your party colleagues, you vote however you want. You know if you do that in some committees you'd be punished by it. But this is an independent Board you can vote how you want.” (LA1, LB Member)

Generally, however, when asked about this in interviews, LB members were consistent in confirming that they were free to make their own decisions, and that this was how they preferred it. This preference is illustrated in this quotation:

“I can sit beside an Independent⁴⁹ pal but take a different decision on a particular issue. I think that's the way it should be and I see other party folk doing exactly the same, arguing with each other. You've forgotten your political affiliations and I think that's important. I think that's the way it should stay.” (LA3, LB Member)

Despite the above, one LB member from LA1 was critical of those who they perceived to vote along party lines instead of fully engaging with the decision at hand (and its implications), stating that this is “really unhelpful”.

6.3.2 Professional Accountability within Licensing Boards

At the organisational level of professional accountability, data from interviews spoke to the importance of relationships among Councillors on the LB in the context decision-making. Within this, members vote individually on each licensing application instead of seeking a consensus.

“I sit next to the Convenor...I wouldn't say I advise [them] but sometimes I've got to nudge [them] and keep [them] going with things. But we have completely different views. You know, [their] view is, give everybody a licence...I'm the opposite of that, I think we shouldn't give people licences unless there's a need... We have quite different views so quite often I, well, in most occasions I vote against [them].” (LA1, LB Member)

⁴⁹ Referring to a Councillor elected as an 'Independent'

This quotation highlights that LB members can hold very different views on how readily licences should be granted locally, a point which was evident across all three LBs. This particular member demonstrated that s/he was an advocate of reducing the number of licensed premises locally, citing reasons which included public health goals. In contrast, s/he described the Convenor as an advocate of allowing the free market to determine how many licensed premises could survive in a given area, and being unconvinced about the need to pursue public health goals through licensing. Overall, the data from licensing interviewees suggested that members primarily vote autonomously and do not feel accountable to other members within the LB.

6.3.3 Professional Accountability of Licensing Boards to Other Local Alcohol Policy Stakeholders

Licensing Boards' Accountability Relationship with Alcohol and Drug Partnerships

ADPs are the primary alcohol policy implementation partnerships at Scotland's local level of governance, while the licensing system (and its control over alcohol availability) is a key component of progressing towards public health-related alcohol policy goals. In light of this, ADPs and LBs could potentially be working collaboratively towards these goals. However, the data in Section 6.2 demonstrated that LBs are not being held accountable through public-administrative accountability for pursuing their public health licensing objective. LBs often prioritise immediate economic concerns over public health ones, a potential difference from priorities they would otherwise share with the ADP.

In this context, I examined whether there was any discernible form of accountability relationship between LBs and ADPs (in either direction). Despite consciously looking for possible examples, I found that the licensing legislation does not mention ADPs, while ADP interviewees did not report any sense that LBs were accountable to them. Further, in response to specific interview questions, LB members only went as far as saying that they sometimes perceived themselves to be "monitored" by ADPs (i.e. that ADPs are paying attention to the decisions that they make without suggesting that this leads to any further scrutiny or judgement). Overall, it did not appear that LBs were accountable to ADPs (or vice versa), and thus this potential professional accountability mechanism is not currently available for ensuring LBs pursue the public health goals of the Scottish alcohol strategy. This was perceived as problematic by some interviewees, in the context of broader community planning.

The below interviewee discusses this with reference to the 'community plan', known formally as the Local Outcome Improvement Plan (Scottish Government, 2019a):

"although the Licensing Board is independent from the Council, they can't really be independent from the community plan, not in theory because the community plan should be everything we're trying to achieve for [LA1]." (LA1, ADP Member)

This led me to observe an important tension for ADPs and their alcohol policy implementation practice given that LBs are not accountable to ADPs. There remains a perception among both ADP and national level interviewees that ADPs should still attempt to engage with LBs to support progress towards the public health objective. For example, when asked about LB accountability, a small number of national level interviewees indicated that ADPs could have a role in influencing licensing:

"we did a lot of work to try and support local ADPs, local public health and trying to get licensing boards to have a different approach and ADPs are now far more involved in licensing than they ever were," (National Level 9)

"I think ADPs do have the potential to influence alcohol availability, in particular at the local level. To be a strong, and vocal actor in licensing decisions, at a local level." (National Level 7)

Additionally, in interviews with ADP members in each participating local area the issue of licensing arose as a key issue on which ADPs could be targeting efforts. Interviewees (especially those from LA1) spoke about LBs often, however this was framed as a challenge as they continued to struggle to convince many LB members about the need (and evidence) for a stronger overprovision statement and limiting local alcohol availability. The frustrations experienced in LA1 in particular were linked to the LB's accountability and their interpretations of evidence (an issue discussed further in Chapter 7) – it was perceived as unfair that the ADP was expected to evidence their own decisions, while the LB had much greater discretion, and thus was often impervious to the ADP's recommendations:

"...there's nothing that holds that Board to account. So there's nothing that says to that Board, "Show us how you used evidence in developing your policy." Whereas for many other areas of decision-making you'd be asked to set that out. You'd be asked for an annual report that said "What've you done this year, what was your evidence behind doing it", those sorts of questions. It's just not happening for Licensing Boards" (LA1, ADP Member)

Additionally, within this same LA that had a relatively weak overprovision statement, there was a recognition of other, interlinked local priorities which may be a barrier to stronger measures, and a sense of futility about creating positive change through licensing:

“the economic climate has tempered our aspirations a bit on what we can achieve around overprovision...So you start to say well, you know we’re never going to reduce [availability], there’s such a drive to get tourists to come to [LA1].” (LA1, ADP Member)

In contrast, in LA2, where the overprovision statement within the Licensing Statement was already more stringent (i.e. more localities in the LB’s area were labelled ‘overprovided’ by the LB), licensing was reported by the ADP administrative team as being of less concern to them⁵⁰. When asked specifically about their relationship with the LB, interviewees from LA2 still identified this as relevant for their Health Board colleagues who attended LB meetings as statutory consultees, but otherwise reported the ADP did not have an active relationship with the LB. For example, a member of the LA2 ADP stated that the Clerk of the local LB was a member of the ADP, but “never attends any meetings”. This person further described trying to avoid the significant responsibility that would come with being given the remit of negotiating the ADP-LB relationship:

“The ADPs used to employ somebody who...all they were doing was licensing work. That person moved on and then the Health Board basically expected myself and [colleagues] to take on that role... [Chair of ADP] was very unhappy with this, and he did escalate that to say basically [I’m] not touching this with a barge pole.” (LA2, ADP Member)

Neither national nor local interviewees provided further detail about how ADPs could address this tension and fulfil the vision of becoming ‘a strong and vocal actor in licensing decisions’. Further, there does not seem to be an indirect accountability mechanism incentivising LBs to more actively consider ADP evidence-informed recommendations – neither the local Council nor the Scottish Government appears to be in a position to ensure this occurs. Thus no legal, political, or social

⁵⁰ An analysis from AFS in 2018 has shown the total number of alcohol outlets in this area has indeed plateaued between 2012-2016 (reference not provided to maintain anonymity). I also contacted LA2’s Licensing Clerk to inquire whether the LB in LA2 was actually not granting some licenses in response. The Clerk provided minutes for the LB, in which I could confirm that they were not granting some licenses (or license variations, e.g. increasing off sales capacity) on the grounds of overprovision.

accountability mechanism is assisting ADPs in these efforts, and LBs continue to be free to make decisions without reference to the expertise or suggestions of ADPs. Therefore, a tension remains between the expectation that ADPs will influence LBs (which is likely to require considerable time and resources to undertake these efforts), and the (lack of) governance structures capable to addressing this expectation.

Licensing Boards and Local Licensing Forums

Local Licensing Forums were created under Section 10 of the *Licensing Act 2005* to “keep under review the operation of the licensing system in their area and to give advice and recommendations to the Licensing Board.” (Scottish Executive, 2007, p. 73). In turn, the LB must “have regard to any advice given, or recommendation made, to them” from the Forum (Scottish Executive, 2007, p. 73). This suggests that Licensing Forums provide oversight and scrutiny of the work of LBs, and that they therefore may have a function in holding LBs to account – this is now interrogated further.

While Forums often convene quarterly, the Forum and LB are only mandated to formally meet once per year (Scottish Executive, 2007). Licensing Forum members must include a licensing standards officer and a representative from the local health board, however members may include other interested stakeholders, such as alcohol license-holders or local residents (Alcohol Focus Scotland, n.d.; Scottish Executive, 2007).

The limited research that exists suggests that Licensing Forums and their impact are often perceived negatively by licensing stakeholders (MacGregor et al., 2013). These perceptions have been linked with issues with the functioning of Licensing Forums, including inadequate leadership and commitment from existing members; lack of clarity about the Forum’s role, remit, scope and power; and variability in quality relationships with LBs (MacGregor et al., 2013)

LB Guidance states that LBs must provide reasons should they decide not to act on Licensing Forum recommendations (Scottish Executive, 2007), suggesting that an LB has an obligation to explain and justify their conduct to the Licensing Forum - a key component of the definition of accountability relationships used in this research

(Bovens, 2010). However, this 'obligation' seems to be the extent of any accountability component of this relationship, with Licensing Forums lacking any power to further interrogate these decisions or trigger consequences for LBs. Interviewees from LBs portrayed this relationship as largely administrative:

"I think we have to meet the Forum twice a year...they meet with us to present some suggestions or recommendations to the Board. And I think officially we're supposed to, well we're supposed to look at the recommendations or other suggestions, and give them feedback, we have to give them feedback. So yes we'll take that on board when we put our policy in place, or no we won't and here's why not." (LA1, LB Member)

This relationship between LBs and Forums sits within the broader governance system of local alcohol licensing, where different perspectives on public health evidence across groups appear to at least partially reflect their professionally diverse memberships. For example, the quotations below demonstrate the relative consistency with which alcohol policy implementers concerned with public health view Licensing Forum members focused on trade as having been unconvinced by public health evidence.

"You'll have the NHS there for the public health licensing objective...But then, there's the trade representatives, who are perhaps not so persuaded." (Deputy Clerk to LB)

"The relationship between public health, myself and the Licensing Forum has not always been a good one...We have a different perspective on life...I'm often, along with some of the Women's Aid people and often the health improvement from the council, we often disagree with members of the Licensing Forum, and it's because they've got a trade, they call themselves from the trade, which means that they sell alcohol or have sold alcohol in the past." (LA3, ADP Member)

Overall, the data suggest Licensing Forums have limited influence on alcohol policy implementation, and generally act in a limited capacity as a consultee to LBs, particularly when LBs are developing Policy Statements.

Licensing Boards and Other Council Committees

The first results section on public-administrative accountability identified that LBs are not formally accountable to the local Council hierarchy. From a professional accountability perspective, however, interview data drew attention to the potential for

informal accountability relationships between LBs and other local Council committees. For example, one LB member reported:

“There is pressure to [bring jobs to certain areas]. And there can be pressure not just from the trade and industry itself but there may be pressure from other Council committees, like Economic Development...I don't think any of our Board members sit on economic development but that would to me be a conflict if you're talking about wanting to bring prosperity to this deal on one hand and then sitting on a Board which says potentially, no, you can't have a licence.” (LA1, LB Member)

Further data illustrated LB members' concern for the economy and informal sense of obligation to the local Council. As an example, the below quotation positions the LB in relation to other local decision-making bodies, and suggests that these bodies are disconnected. In this example, a local Planning Committee approved an application for a premises, which was rejected for an alcohol licence by the LB. The alcohol license was subsequently approved:

“...the overprovision policy was brought in, a short time afterwards somebody wanted to convert one of the older builds into the [on-sale wine-based premises], and they came to the Licensing Board and the Licensing Board said well, overprovision, you can't have a licence. So we've given them planning permission, to change a building, and we knew it was going to be a wine-based [on-sale premises], and then they came to get an alcohol licence and we said no. Bizarre situation, but that's independence of two quasi-judicial bodies planning and alcohol, and they come to different outcomes. Which is legitimately the right thing to do, but it didn't make [LA1] look very clever...It was overturned and they got the licence in the end.” (LA1, LB Member)

Although not formally accountable to other Council committees, the quotation describes what could be perceived as an informal accountability relationship between the LB and the local Council: The LB's decision was judged as problematic because it appeared to conflict with a decision made by another part of the Council, with consequences for the LB in having to reverse their decision. Overall, the data here suggested that although direct, formal accountability often does not exist for LBs, members are sensitive to their broader political and economic context. In accountability terms, this further supports the idea that public health goals (or indeed

public health objective) within Scotland's alcohol strategy will not be their primary consideration when making decisions.⁵¹

6.4 Participatory Accountability of Licensing Boards

This section focuses on the potential accountability relationships between LBs and the public. This refers to involvement of citizens or public bodies who can, or may be positioned to, evaluate the work of local alcohol policy implementers (Hupe and Hill, 2007).

6.4.1 Accountability to Non-Government National Stakeholders

The typology from Hupe and Hill (2007) lists actors such as national interest groups and the media as acting at a system-level of participatory accountability. In Scottish alcohol policy, this includes organisations such as AFS, SHAAP and (UK and Scottish) media outlets. Concern about LBs' role in reducing alcohol-related harm in Scotland has been expressed by advocacy organisations, who have hosted events and developed materials focused on licensing (e.g. see (Alcohol Focus Scotland, 2016a, 2014b, 2014a). For example, AFS hosts mandatory training for new LB members (Alcohol Focus Scotland, 2017d).

Despite AFS' and other organisations' roles in the Scottish alcohol policy landscape, there is no evidence in the interviews that LB members feel meaningfully accountable or responsible to AFS or similar alcohol policy stakeholder groups. This was articulated clearly by a LB member from LA1:

“Groups like Alcohol Focus will come along and sit and watch and make comment. Our particular Convenor will ignore that totally and utterly...When we have joint forums and things he will listen to them and be quite dismissive. As will some of the other members of it.” (LA1, LB Member)

In addition to asking about organisations such as AFS, I also asked about the broader news media as a possible source of public accountability. However, LB

⁵¹ As an additional note, the data did not explore whether LB members were aware of, or perhaps unconvinced by, evidence which shows that alcohol-related harm is damaging for the economy.

members rarely commented on it, and those that did (both from LA1) dismissed it as a source of accountability:

“we have a very critical media in [LA1], some would say overly critical. I would genuinely say that most Councillors have the attitude when they pick up a local paper say, 'right what've we done now?'...So I don't worry too much about the media (LA1, LB member)

“I can't think of any media reports that have made me think I'm making the wrong decision here I need to reassess it.” (LA1, LB member)

It seems that while LB members do engage with the media, speaking familiarly about local papers and media reports, they do not consider it to be particularly important for their own decision-making.

Despite the above, there was one notable instance in which interviewees reported that a community's lobbying and social media had influenced an LB's decision about whether to change local nightclubs' curfew hours. An LB member, who was Convenor at the time, states:

“we were really, really heavily lobbied by the public [to abolish the curfew], by the younger generation. And, you know, it's actually good when you get the younger generation involved in something, because they don't usually bother to get involved in anything. So there were lots of Facebook media...active groups setting up and all sorts of things” (LA3, LB Member)

This person reports that the LB was split on the vote about abolishing this curfew, but that s/he had the casting vote and decided to abolish it. This particular story does not demonstrate a formal accountability of the LB to the public, but does seem to suggest that the LB can be influenced by an interested public – in this case a group which was perceived to be a fresh voice, that had become loud and active enough.

6.4.2 Accountability to Local Communities and the Public

In their 2003 review of the Scottish licensing system, the Nicholson Committee highlighted a need for increased community involvement (Scottish Executive, 2003). This was taken forward in the Licensing Act 2005 by establishing the right of the public to object to licence applications and including local residents as consultees on

the LB overprovision statement (Nicholls, 2015; Scottish Executive, 2007). One LB member indicated that the public may have a role in the accountability of LBs, although s/he seemingly perceives this role to be as a passive audience:

AW: What extent do you think that the Licensing Board is being monitored and evaluated by anybody?

Interviewee: Well, it is a public meeting so in that sense I suppose members of the public can come and listen to us while we deliberate.” (LA1, LB Member)

Other data showed that although some members spoke broadly about their concern for their communities (e.g. whether they perceived alcohol-related problems are affecting their constituents), they did not report feeling accountable to the community for LB decisions, despite being asked about their constituents during interviews. For example, one LB member in LA1, when asked about whether their constituents’ views influenced decision-making, said they did, but only “up to a point”.

The data also generated observations about whether the existing licensing decision-making system enabled or challenged members of the public if they attempted to engage. For example, one LB interviewee highlighted how the governance of licensing may prevent the public from engaging with decision-making, and thus possibly preclude any capacity to hold LBs to account:

“we had a long, long discussion about our policy on overprovision, previously and in the end it was decided by the Convenor slipping round a bit of paper literally two minutes before we were to take the decision, slipping round a bit of paper, not giving us the adequate time to read it and saying do you accept this or not? That to me is not transparent or democratic or accountable...and the fact there are no standing orders means [s/he] was perfectly within [her/his] rights to do it that way.” (LA1, LB Member)

In addition, there was evidence that LB members may not perceive members of the public to be capable of fairly monitoring their decisions, and thus as not well positioned to comment. For example:

“my local community council were delighted that an extension to a licensed restaurant was refused, and it was, “first time that's happened in a long time”, actually no that happens every month, but you only come when it's in your area... even if you were to keep a score of how many applications were applied for, how many were granted against objections, you would have to actually know and be able to score the objection...[for example] it was by somebody who stayed 3 streets away, who just doesn't like people

drinking. That's completely different to objections sayin' 'this is a problem bar that really has been a problem for years'...completely different circumstances. So monitoring fairly Licensing Board decisions would be quite a complicated business because you would need to, you would have to score the level of objection I would think. (LA1, LB Member)

This quotation from a LB member highlights intrinsic difficulties for the public in monitoring of LB decisions, itself indicating a potential lack of governance mechanisms in LBs to make them sufficiently open and transparent to the public, so as to be more easily engaged with. This is consistent with previous critiques of the Scottish licensing system that it is largely inaccessible to the public (Alcohol Focus Scotland, 2017e).

Considerations of Public Interests Interpreted as Economic Concerns

The findings in this research suggest that any active accountability that LB members feel towards the community is based primarily from their role as elected Councillors (related to concerns with re-election), not as LB members (with a responsibility for the public health objective). I had initially thought that the political nature of Councillors/LB member's roles would lead them to feel accountable to, and cognisant of, the public health desires of their local community. In practice, this type of participatory accountability seems to lead LBs to privilege concerns about the economic livelihoods of local constituents and the availability of jobs.

For example, in the rural local area included in this research, there was concern about the community's vitality:

"we have got a difference here, because of all the rural localities. 'Cause a lot of the time, the pub is the centre of the whole village. And the trouble is with a lot of the rural pubs, a lot of them shut down is, it takes the centre of the village away." (LA3, LB Member)

This indicates the contextual decision-making of LB members, in which not just the economic, but also the socio-cultural context of a local area influences their sense of how licensing will impact on their local community, which then informs how they respond to this sense of informal accountability to their constituents. A quotation from a police representative involved in licensing also reflected this tension:

"you're asking them to object to a licence for that pub or that supermarket, when they know it's going to generate so much

money in a community that's run down, that's needing that injection...hopefully they just try and make decisions that they believe are the best for communities and people in [LA1]. And whether that's injecting money and jobs into an area to the detriment of putting more alcohol into that area, so even people susceptible to increased availability and increased consumption and things like that, but it's all a balancing game.” (LA1, police representative)

One source of information about community needs is public consultations. By law, LBs are expected to carry out consultations when developing their Licensing Policy Statements. However, similar to variation observed around development of LB overprovision statements, there is variation in LB commitments to public consultation. While I did not ask about this issue specifically in interviews, it arose in one interview with an LB member in LA1:

Interviewee: The clerks drafted up...our current statement of policy. We went out to consultation. I can't remember exactly what the questions we went out to consultation with were but I think it was quite broad. "Here's a previous statement of policy. Do you have any suggestions for how they should change?"

AW: Was that to the public?

Interviewee: Yes.

AW: Okay. Where is that sort of thing advertised?

Interviewee: On the council website.

It is not clear how effective this consultation was, nor how accessible this type of consultation would be, especially if only advertised on the Council website.

6.5 Discussion

This chapter addressed the question of how the implementation of Scotland's alcohol strategy in Licensing Boards was influenced by formal and informal accountability mechanisms. To do so, it explored the accountability regime surrounding local LBs, which are positioned as contributing to alcohol policy implementation and the achievement of public health outcomes via the regulation of alcohol availability (Scottish Government, 2009a).

Similarly to Chapter 5, this chapter drew upon the Hupe and Hill (2007) public accountabilities typology. Reflecting on its use here, and by contrast with ADPs, it was not necessary to modify the framework to include 'partnership' accountability because LBs are not structured as partnership organisations. Drawing on the

framework became particularly useful for identifying where accountability was perhaps assumed to exist but, in practice, appeared absent.

6.5.1 Principal Findings on Licensing Boards' Accountability Regime and Contribution to Literature

The public health objective makes Scotland's approach to licensing unique in the UK. However, the principal findings suggested that LB members are not held sufficiently accountable for pursuing and protecting public health to enable this objective to make a meaningful difference to licensing decisions. In particular, accountability mechanisms surrounding licensing do not currently ensure the objective can have a meaningful impact, given a tension between what the existing legal and policy framework surrounding alcohol licensing says about the importance of public health, and the limited traction that public health arguments appear to have in alcohol policy implementation practice among licensing stakeholders. The absence of a regular mechanism to ensure LBs are fulfilling their public health-related obligations means their decisions often present a challenge to alcohol policy implementation and, therefore, to the achievement of stated alcohol policy goals regarding alcohol availability.

Legislative and Legal Tensions

The findings suggested that public-administrative accountability of LBs was characterised by legal appeals-based mechanisms, and there was an overall absence of formal (and very limited informal) professional or participatory accountability influencing LB members. The fear of costly appeals appeared to be the strongest formal accountability-related influence on LBs' licensing decision-making. This finding reaffirms understanding generated from public health actors' about what mechanisms influence Scottish LBs (Fitzgerald et al., 2017).

While a legal accountability system exists to regulate LBs, the arrangements are arguably not conducive to effectively protecting public health interests. The data show that public-administrative accountability of LBs relies on legal accountability arrangements; beyond this there is a lack of other formal mechanisms for holding LBs to account. This creates challenges for alcohol policy implementation and public health in this process, because any gaps or failures within legal accountability

processes to support alcohol policy implementation cannot be mitigated by other mechanisms. While LB accountability is reliant on legal mechanisms, the practical arrangements are characterised by substantive flexibility and a de facto imbalance towards wealthy industry stakeholders.

This leads to two observations. First, LBs' flexibility to interpret legislation and the licensing objectives permit them to contextualise the legislation ('in light of their particular circumstances'), and can go so far as to allow them to ignore the 'spirit' of the legislation in terms of an understanding and concern about public health impacts of availability. This finding adds to existing literature on alcohol policy implementation by providing greater understanding about how a lack of accountability can potentially contribute to variation in implementation. For example, the finding of variation in implementation is aligned with results from literature reviewed in Chapter 3 (e.g. the 'room to manoeuvre' identified by Herring et al. [2008]). It is also consistent with a review of LB Policy Statements by AFS which showed that overprovision statements were varied in their breadth and strength (Alcohol Focus Scotland, 2014a), suggesting interpretative flexibility of availability-related evidence. However, this analysis provides an in-depth examination of the role accountability may play in this variation.

Second, the observed imbalance towards wealthy licence applicants suggests LBs are only held to account in legal terms by applicants who have the financial resources to challenge their decision-making on a legal basis. Hence, while the court case regarding MUP positioned the alcohol industry as an adversary of government and its public health goals (Gillan, 2012), the accountability structures and practices surrounding alcohol licensing at a local level continue to favour large industry retailers, and serve to largely exclude public health stakeholders. If this is the principal mechanism for holding LBs to account, this excludes (a) alcohol policy implementers such as ADPs and their member organisations from holding LBs to account, because they cannot engage in the system in this manner, and (b) less financially secure licence applicants (or community members who do not have a financial interest in the outcome). The imbalance in this power distribution favours larger economic actors with access to significant resources, namely large industry producers and on- and off-trade retailers. This creates a system in which industry

actors are the most empowered to challenge the system that exists to regulate alcohol availability.

These findings are aligned with existing research in which public health actors perceive licensing processes as unfair, disempowering, and favouring of well-resourced licensing actors (Fitzgerald et al., 2018). These findings also align with a discussion of legal accountability by Hill and Varone, where they highlight that the “law may be comparatively impotent in the face of complex issues of administrative discretion” and that this concern “stimulates a search for other models of accountability” (Hill and Varone, 2017, p. 344). However, my findings go beyond this to show that the resources required to use the legal mechanism available mean the system actively shifts the balance of influence to favour interests which are counter to public health.

The problem of the licensing system serving to privilege large retailers appears to be perpetuated by the way the system traverses multiple policy areas, i.e. justice/legal and public health, which have different approaches and priorities. However, it has been observed that public health seems to generally be losing in contests against competing economic or justice priorities. Ultimately, the dominance and characteristics of legal accountability for LBs help explain the gap between what is formally set out in Scottish alcohol licensing legislation and policy (i.e. a clear public health focus) and what is observed in practice (i.e. the extremely limited traction of public health considerations).

Democracy, Accountability, and Public Health in Scottish Alcohol Licensing

Fitzgerald and colleagues (2018) have made an important previous contribution to exploring democracy and power in Scottish licensing, finding that public health actors perceived members of the public are generally supportive of overprovision, and that ongoing involvement of the public in licensing was critical. My analysis in this chapter builds upon their findings by highlighting that characteristics of local democracy contribute to the gap identified above - in particular in relation to the roles of locally elected Councillors and the relationship between Scottish and local governments.

The first example relates to local democracy, accountability, and the economy. My data suggested that while LBs have a formal responsibility regarding the public health objective and no formal responsibility for being concerned with the economy, their operational concerns reversed this focus. This could be a function of their simultaneous status as elected councillors and as LB members. In terms of democratic accountability, as councillors, they have a responsibility for the economic wellbeing of their local area because they have been elected by their local community. However, in terms of legal accountability, LB members have responsibility for public health, not economic concerns—the document guiding their decision-making states that commercial considerations are irrelevant to a policy which is designed to protect the wider public interest. Therefore, it is arguable that their simultaneous roles of elected councillor and LB member seem to be in conflict, and that their democratic accountability and legal accountability are also in tension.

A second component of the analysis related to local democracy observes differences between elected and non-elected alcohol policy implementation stakeholders; Councillors experience democratic accountability which local, non-elected policy implementers do not. In light of this, there is a tension inbuilt to the position of an LB member, which has implications for how alcohol policy implementation is governed. Elected Councillors are not part of the same systems of accountability as non-elected local government officials. However, the NPF identifies health as a Scottish priority, and LBs have a direct influence in contributing towards the alcohol-harm-related goals of the NPF because they control the availability of alcohol⁵². It appears that their role as a LB member is again in tension with this Councillor role, because being a LB member is a policy-led, administrative position which is explicitly intended to contribute to central Government goals relating to alcohol-related harm (MacNaughton and Gillan, 2011), and one would presume that they should, as such, be held accountable for this policy work. Yet, my research identified no obvious mechanism through which LB members were held to account for this work.

⁵² Note, an updated 2018 version of the NPF states both ‘increased wellbeing’ and ‘economic growth’ as the foundational components of the government’s Purpose (Scottish Government, 2018d).

Third, LBs have a different arrangement of formal accountabilities than other alcohol policy implementers, who are subject to more explicit accountability and reporting mechanisms within local and national governance systems. These differences are important because, as a consequence, LBs have greater discretionary powers and are subject to less oversight than other local policy implementers (e.g. ADPs). For example, LBs are quasi-judicial bodies which sit independently from the established accountability regime for other local Council committees (Cllr L Young, 2018, personal communication). Thus, although LBs make decisions that influence the local populace and may impact on local government progress towards their own strategic priorities, they sit beyond the accountability arrangements that could monitor LBs. This includes lacking accountability from other local government bodies or through public involvement. This is problematic because, if their actions present a barrier to the achievement of local strategies, local actors do not have any recourse to hold them to account (i.e. data showed ADPs are having a limited impact on LBs in this context, despite the expectation that they will influence LBs). This demonstrates a key aspect of the LB accountability problem for alcohol policy implementation: while LBs sit beyond the system of accountability applied to other alcohol policy implementers, they will continue to present a key challenge to achieving availability-related alcohol policy goals. As an example, decisions by LB members about their Policy Statement have an effect on the alcohol policy implementation practice of ADPs (e.g. leading to increased time and resources spent on licensing issues) despite the sense that these efforts may be futile.

Context and Resources

The results presented and discussion above have touched on a number of aspects of context and resources which appear to influence the nature of LB accountability, and in doing so, influence Scottish alcohol policy implementation (e.g. see p. 204, 206, 218, 221, 225).

It has been made clear that concern with the local economic and financial context was an influence on LB decision-making, evident in LB members' concern with the economy and, in relation to resources, their fear of the cost of appeals in court. The data in this regard also indicated there is an informal but strong concern among LBs of not wanting to contradict or impede the actions of another committee, suggesting

they were influenced to a certain extent by their local political context. In LA1, this was framed in terms of the Planning Committee wanting to bring 'prosperity' (a positive framing) and the local LB potentially making a decision which would go against prosperity (see page 221). If public health stakeholders are concerned with how LB members seem to prioritise the local economy over public health (and the barrier this creates for alcohol policy implementation), then they may wish to engage in the broader local discourse surrounding this issue. For example, this may require better understanding of the context in which LB members are working, and help them reconcile economic and public health concerns.

This finding is broadly consistent with Foster (2016), who writes about licensing in England and Wales and found that while the licensing legislation in this context did not take economic issues into account, some of the study's interviewees "described the economy as the 'unofficial fifth [licensing] objective'" (p. 71). Foster ultimately recommended that a new licensing objective be introduced to "promote sustainable economic development and the wellbeing of the locality" (p. 15), or for England/Wales to adopt the same 'overprovision' concept as Scotland. While this recommendation seemingly aims to bring greater standardisation to licensing decisions made on the basis of economic considerations, Foster does not suggest how to overcome the difficulties in implementing 'overprovision' that are evident in the chapter findings above and in other existing research (e.g. MacGregor et al., 2013).

Finally, related to the democratic governance context of LBs, interviewees in the study by Fitzgerald and colleagues (2018) have suggested potentially influencing or holding LBs to account through the power of the voting public. My findings countered their participants' perspectives somewhat, because my data suggested LB interviewees did not perceive LBs to be directly accountable to their communities for licensing decisions. Literature from Chapter 3 (e.g. Fitzgerald et al., 2018; Foster, 2016; Herring et al., 2008) has called for increased public involvement and consultation. While this may be valuable in its own right, whether this would provide an accountability mechanism for LBs to pursue public health goals would require further exploration. Overall, however, in light of these contextual factors, local politics and councillors' democratic accountability need to be acknowledged as

important considerations underpinning LB accountability processes, with implications for alcohol policy implementation.

6.5.2 Implications for research and practice

The findings in this chapter suggest there is a gap between the intentions of licensing legislation with respect to public health and the way it is enacted in practice. If the Scottish Government is serious about achieving its public health alcohol policy goals, both the absence of a clear accountability mechanism for LBs' contributions to these goals, and the tension between these goals and the other priorities of LB members, need to be addressed.

While the results presented in this chapter are aligned with existing research suggesting the public health objective has been difficult to implement (Macgregor et al., 2013; Fitzgerald et al., 2017) they also suggest that the lens of accountability is an important component of explaining why implementation has been challenging thus far. They lend support to an analysis which is focused on the accountability mechanisms surrounding licensing decision-making and its relationship with alcohol policy implementation.

This chapter does not claim that giving licensing actors a responsibility to contribute to alcohol policy implementation has failed, or indeed that the public health objective itself has failed. Instead, it suggests that the implementation of the licensing system and the public health objective are suffering from challenges that are well-recognised in the wider policy implementation and governance literature: that it is insufficient to develop public health policy or legislation and expect that the implementation of this will straightforwardly follow from this top-down decision. In this case, this problem is particularly acute given the complex interplay of public health, economic, democratic, and governance concerns which influence the decisions and actions of alcohol policy implementation stakeholders. The key message, however, is that national alcohol policy in Scotland is likely to continue to fall short of intended goals if tensions between overarching goals and local practices remain and these tensions seem unlikely to be resolved without meaningful changes to the accountability regime.

6.6 Conclusion

This chapter adds to existing literature an empirical investigation and mapping of LB accountability and how this influences the implementation of Scotland's alcohol strategy. It draws lessons from accountability literature, and combines data from interviews with both public health licensing stakeholders as well as LB members themselves.

This chapter studied how the implementation of Scotland's alcohol strategy was influenced by formal and informal accountability mechanisms and relationships surrounding alcohol licensing decision-makers. It found that their regime is characterised by a nearly exclusive dependency on legal accountability, and a relative absence of other public-administrative, professional, and participatory accountabilities. In terms of implications for how local Scottish alcohol policy implementation occurs (including enactment of the 'public health objective') it highlighted a tension between the intentions of licensing legislation and the way it is enacted in practice. In particular, it suggests that there are a lack of accountability mechanisms within the regime governing Scottish LBs to ensure they contribute to the public health goals of the Scottish alcohol strategy. From a public health perspective, this has perpetuated a system in which LBs continue to act with problematic levels of flexibility and autonomy from the rest of the alcohol policy implementation system. Consequently, this creates a significant challenge to alcohol policy implementation and the achievement of Scotland's alcohol policy goals related to the reduction of alcohol-related harm. In the context of limited empirical alcohol policy research which examines the interplay between alcohol policy implementation and accountability, and in light of the above, this chapter makes an empirical contribution to understanding how and why different types of accountability (or lack thereof) which help to govern licensing stakeholders influence the effectiveness of alcohol policy implementation in Scotland.

The final results chapter is presented next, and turns to focus on the role of evidence in the context of Scottish alcohol policy implementation.

7 “Shades of grey”: Evidence, Expertise, and Experience among ADPs and Licensing Boards

7.1 Introduction

The purpose of this chapter is to explore the role of evidence in implementing Scotland’s 2009 alcohol strategy. It investigates how members of ADPs and licensing stakeholders perceive and use evidence in the context of their alcohol policy implementation work. I begin by briefly discussing my rationale for studying this topic and reflect on my approach in this chapter, followed by a discussion of relevant literature. The chapter then transitions to presenting the results and discussion.

7.1.1 Rationale for Studying Evidence Use in Scottish Alcohol Policy Implementation

The systematic review (Chapter 3) identified evidence use in alcohol policy implementation as an important area for study, but that existing literature left research gaps requiring further empirical exploration. These findings helped to inform the development of this chapter. For example, geographically, literature often focused on English/Welsh contexts (e.g. Toner et al., 2014) and, methodologically, was often based on a limited number of interviews with public health actors (e.g. Fitzgerald et al., 2017; MacGregor et al., 2013). In the Scottish context, there remains a gap in understanding about perceptions and uses of evidence by ADPs (and their diverse members), particularly with respect to how ADPs use evidence in their structure as multi-sectoral partnerships. This dynamic has not yet been explored, yet seems critical to understanding alcohol policy implementation. With respect to licensing, the systematic review identified that accessing licensing actors’ perspectives first-hand would provide an opportunity for enhancing existing understanding about their approaches to evidence. Taken together, existing literature has thus far provided limited explanation of, or ideas for how to address, the ‘epistemological discord’ (Nicholls, 2015) between public health and licensing actors in their approaches to evidence – an issue previously identified as presenting a barrier to implementation (Fitzgerald et al., 2017). Examining ADPs and LBs together in the context of local alcohol policy implementation provides an opportunity to contribute explanations to this issue.

The rationale for exploring the issue of evidence use in Scottish alcohol policy implementation was additionally informed by the Scottish Government's explicit claim of having developed the 2009 strategy as an evidence-informed policy⁵³, a claim supported to some extent by subsequent evaluations (e.g. Fitzgerald & Angus, 2015). However, in-depth understanding of the role of evidence within the implementation of this strategy is still required. My analysis of national level interview and document data underlines the 2009 strategy's claim that the implementation was intended to be an 'evidence-based' process, at least in ADPs (it is less clear that this expectation extended to LBs). For example, national level interviewees explained how 'evidence-based policy making' is a component of best practice for ADPs and is linked with their accountability obligations:

"having a national dialogue across all of the local ADP areas, is really important, in order to further encourage best practices, in a number of areas. And evidence-based policy making is certainly one of them" (National Level 7)

"[Annual reporting] would be a circumstance where a fair question would be can you evidence that? And by evidence I think we'd be looking for both quantitative and qualitative evidence...you need to have a plausible argument. You need to have worked out your logic models as we did. And then be clear what the plausible connection is." (National Level 4)

In contrast to the expectations that ADPs would use evidence in implementing policy, there did not appear to be a similar, explicit expectation of LBs or their members. However, LBs are expected to work within the framework provided by the licensing objectives in the *Licensing (Scotland) Act 2005*, and guidance for the public health objective encourages LBs to consider evidence on alcohol availability and harm in their decision-making regarding overprovision and individual licenses (see Chapter 2). Nonetheless, during interviews, it became apparent that while LB members did not perceive an explicit expectation from national-level to use evidence, they were regularly doing so. Analysing further the perspectives and uses

⁵³ This claim appears again in the *Alcohol Framework 2018*, which states "We have taken, and will continue to take, an evidence-based approach to our alcohol strategy" (Scottish Government, 2018a, p. 8).

of evidence among ADPs and LBs within these contexts seemed an important line of inquiry in this thesis⁵⁴.

I wish to reflect briefly on my approach and analysis for this chapter. Following my chosen definition of implementation from O'Toole (Chapter 3, p.41), I have interpreted that the local policy work in which my interviewees are engaged is all 'implementation' work. I brought this viewpoint to my interviews and my analysis of the data. For example, while I did sometimes ask interviewees whether they could think of specific examples in which they used evidence in making decisions, I allowed them to discuss their evidence use within the broad context of their work, and did not press them to demonstrate how this evidence use could be directly linked to a specific implementation action. I undertook the interpretive task of linking evidence and implementation myself when analysing the data - I found that the data helped me understand the role of evidence within implementation as defined, and to identify consequences of the findings for implementing the Scottish alcohol strategy. I perceived this approach as useful and appropriate in the context of my interviews, because I felt my interviewees were more comfortable talking about evidence use in general terms as related to their work, without always having to speak specifically to actions they have taken to implement aspects of the 2009 alcohol strategy. This approach also acknowledged understanding from evidence and policy literature that recognises evidence use is often not instrumental (Nutley et al., 2007). Further, LB members sometimes indicated they did not perceive themselves as strictly being 'implementers' of alcohol policy (Chapter 6), therefore I felt forcing them to link their evidence use to narrowly-conceptualised implementation actions may have been detrimental.

⁵⁴ I remind the reader that I modified my interview schedule after reflecting on my experiences asking about evidence use in LA1 (Chapter 4). However, I do not perceive that this led to significantly different results across the three areas with respect to my findings on their evidence use. As the results of this chapter will show, the data across the three areas supported identification of a 'culture of evidence' for ADPs and one for LBs.

7.1.2 *Engaging with Relevant Literature*

There is a wealth of existing research regarding evidence use in policy, key areas of which have been usefully reviewed and provide background knowledge for this chapter. First, these reviews demonstrate that decision-makers source evidence from diverse scientific and non-scientific sources and use different types of evidence (e.g. Masood et al., 2018; Orton et al., 2011). For example, public health policymakers have been found to source information mainly from Government websites, the National Institute for Health and Care Excellence (NICE), and through personal contacts; sourcing evidence less frequently from academia or online journals (Oliver et al., 2017; Oliver and de Vocht, 2015). Second, relevant research suggests that the types of evidence policy-makers access are often local data and needs assessments, as well as practical guidelines and surveillance data (Oliver and de Vocht, 2015). It has also been noted that individuals' own opinions, preferences, or interests (even within an organisation, network or other group) will influence their perceptions of evidence (Contandriopoulos et al., 2010).

Third, there is a well-developed literature around what factors can influence evidence use in policy. These have included availability and access to research; clarity, relevance, or reliability of research findings; timing of research; and interactions between researchers (or other evidence producers) and evidence users (Contandriopoulos et al., 2010; Kneale et al., 2017; Nutley et al., 2007; Oliver et al., 2014; Walter et al., 2005). A recent systematic review also notes that barriers to evidence use can be individual, organisational, related to aspects of the research itself, or be related to the social, economic, or political environment (Masood et al., 2018). Fourth, there has been much discussion about how evidence influences policy decision-making, with models showing a multiplicity of mechanisms for how this occurs, from direct, instrumental uses to indirect, complex, or more conceptual uses (Best and Holmes, 2010; Nutley et al., 2007; Orton et al., 2011; Weiss, 1979).

For this research project it is valuable to consider that the literature suggests context (e.g. social, economic, political, institutional) is critical to understanding how evidence is being, or will be used, in policy (Contandriopoulos et al., 2010; Liverani et al., 2013). For example, Liverani and colleagues (2013) emphasise that developing evidence-informed health policy is necessarily a *political* challenge, which will be influenced by factors such as the level of state centralisation, influence

of external organisations, the nature of bureaucracy, and how well evidence aligns with stakeholders' values and political agendas. This is additionally evident at local government level as certain powers are devolved to local areas – a review by Kneale and colleagues (2017) suggests that primacy is given to local evidence and to the knowledge of local experts which is perceived as more readily applicable.

While seeking to apply such insights, this chapter (consistent with the thesis overall) is specifically situated within the alcohol policy implementation literature. To return to the findings of the systematic review (Chapter 3), a number of studies have considered the role of evidence in alcohol policy implementation. For example, studies have reported a perceived lack of (relevant) evidence as a specific barrier to implementation (e.g. Fitzgerald et al., 2015; Foster, 2016; Herring et al., 2008). Others explored actors' perspectives on evidence in different alcohol policy implementation contexts (e.g. Fitzgerald et al., 2017; Martineau et al., 2013; Muhunthan et al., 2017; Toner et al., 2014). For example, certain articles discussed the use of evidence in alcohol licensing contexts (e.g. Grace et al., 2016; Randerson et al., 2018), noting how licensing decision-makers had different perceptions of evidence than public health actors, implying that the evidence which public health actors might assume give their arguments credibility are not necessarily effective in a licensing context. Similarly, in their study of the implementation of Scotland's 'public health objective', Fitzgerald and colleagues (2017) reported that various alcohol policy implementers brought different values and beliefs to their implementation work, which influenced their interpretation of licensing legislation and related evidence. This sometimes resulted in LB members apparently regarding public health evidence as unpersuasive – a finding which is supported by my own data (Section 7.2.2 below). Notwithstanding these contributions, the review suggested that understanding of how key stakeholders use evidence in Scottish alcohol policy implementation remains relatively limited, especially in spaces other than LBs.

In this chapter I have sought to build upon Fitzgerald and colleagues' (2017) examination of Scotland's public health objective, in which they reported on the experiences of 13 public health practitioners engaging with licensing across 20 licensing areas. Their interviewees perceived a challenge to effectively enacting the public health objective in that, while they approached this work with a 'whole

population approach', this perspective was not always adopted by licensing decision-makers (Fitzgerald et al., 2017). Interviewees reported that not all licensing stakeholders agreed that current Scottish alcohol consumption levels and related harms were significant problems, and that the licensing community lacked consensus about whether "addressing public health was a legitimate role of licensing" (Fitzgerald et al., 2017, p. 7). Additionally, interviewees perceived LBs as tending to prioritise economic considerations and concerns over those related to public health (Fitzgerald et al., 2017). This chapter seeks to expand upon Fitzgerald and colleagues' analysis by examining evidence use in the implementation of the 2009 alcohol strategy more broadly, exploring a more diverse set of relevant policy perspectives on evidence use in alcohol policy implementation from across ADPs and LBs. This inclusive lens permits observations about how, for example, ADP members are using and perceiving evidence in their broader alcohol implementation work (which stretches beyond trying to influence LBs), and attain first-hand LB member perspectives on evidence.

In concluding their account, Fitzgerald and colleagues (2017) suggest that the concept of variation in 'cultures of evidence' might usefully be employed in examining alcohol policy implementation. The concept of 'cultures of evidence' refers to observed patterns in how policy actors use evidence and the factors that influence this use (Lorenc et al., 2014b). It was developed by Lorenc and colleagues (2014), out of their systematic review of qualitative research across 'non-health sectors', and rests on the idea that there is a divide between health and non-health uses of evidence. The authors acknowledge the need for research to examine "the actual decision-making process in specific fields" (Lorenc et al., 2014b, p. 1045). In this research, ADPs and LBs have emerged as particularly valuable contexts for such analysis, given their involvement in making health-relevant policy decisions in contexts often shaped by other priorities, and their composition in bringing together actors with diverse professional backgrounds and varying priorities. Thus, this concept facilitated my analysis by helping me to explore complex data about two distinct organisations involved in alcohol policy implementation, and aid in their comparative analysis.

Lorenc and colleagues' (2014) analysis is inherently contextual given their consideration of how cultures of evidence among non-health actors may be different

from those in health. In particular the authors consider how the political context of non-health actors may influence their perceptions and uses of evidence, and implications of this for their relationship with public health research. I wanted to examine the significance of diverse institutional contexts, and the interactions between them, and was inspired by this aspect of their analysis. Their analysis was developed to answer three questions: (i) what is considered to be evidence by non-health decision-makers? (ii) what factors affect decision-makers' use of research evidence? (iii) how do decision-makers use research evidence? In this chapter I did not follow Lorenc and colleagues (2014) in assuming a divide between 'health' and 'non-health' uses of evidence; such an assumption felt inappropriate in the context of examining complex cross-sectoral setting such as ADPs (being potentially both normatively loaded and limiting scope to explore more complex patterning of evidence use). Instead, I used 'cultures of evidence' as an underpinning idea through which to approach the analysis. By using the concept in this way, I was able to go beyond consideration of 'research evidence' to analyse how evidence conceptualised broadly may be influencing alcohol policy implementation. I was also able take into account the complex dynamics within the organisations I was studying – specifically the partnership basis of ADPs, and the diverse personal and professional backgrounds contained within both ADPs and LBs. In light of this, this chapter addresses the question of: What roles (if any) did evidence appear to play in the implementation of Scotland's 2009 alcohol strategy?

The results of this chapter will now be set out in two substantive sections, each describing how the data point to the existence of distinct 'cultures of evidence' among ADPs and LBs, respectively. The results are followed by the chapter's discussion section.

7.2 Results

7.2.1 "We always have to take a nuanced view": ADPs' Culture of Evidence

This section presents data from members of the three included ADPs, in relation to their culture of evidence surrounding work to implement the 2009 alcohol strategy. As will be shown through the data presented, while a general culture of evidence could be identified across the three ADPs, at an individual level members displayed some diversity in their evidence preferences and approaches. Thus the ADP culture

of evidence was made additionally complex by their multi-sectoral partnership composition. Despite the diversity of their partnership membership, the data will suggest an ADP culture of evidence broadly characterised by (i) a general openness to different types and sources of evidence, depending on needs; (ii) a preference for evidence which is contextualised and actionable; and (iii) uses of evidence to inform both personal decision-making and to persuade other policy actors. These characteristics will be the focus of the following subsections.

Using different types and sources evidence to meet different needs

ADP interviewees described drawing upon a wide variety of *types* of evidence to inform their policy work to implement the 2009 strategy, spanning from experiential or informal types such as stories or anecdotal feedback, to data-driven evidence (both at the at national or local level). However, ADP members reported attaching particular meaning and importance to experiential evidence, and, where they did use more data-driven evidence (in particular with respect to quantitative data) they highlighted the need for consistency with the experiential data. Furthermore, ADP interviewees reported using a wide range of organisational- and individual-level *sources* of evidence, including academic research, national-level organisations such as Information Services Division or NHS Health Scotland, data from their own (or other) local areas, and individual-level sources such as colleagues, service users, or other public perspectives. My data further suggested they used evidence in ways which spanned a range of instrumental and conceptual uses (Nutley et al., 2007). With this contextual understanding in mind, the rest of this section expands on the discussion of types and sources of evidence ADPs report using summarised thus far.

First, ADPs reported drawing upon a range of experiential evidence, including professional experience; service user feedback; information from colleagues or other stakeholders; and personal experiences, stories, or ‘common sense’. The following quotation discusses drawing upon colleagues’ knowledge, shared learning, and the professional expertise of others:

“It came from one of the area team social workers and their team manager flagged it up to me... so I said to [NHS colleague], I says ‘this is an issue’, so [we] organised a meeting with a few folk and gave them permission to address that at the grassroots level”
(LA2, ADP Member)

This quotation suggests that the professional expertise of key colleagues was perceived as credible and valuable, and even more importantly actionable, as this interviewee then communicated the issue to another ADP colleague, resulting in a change in practice. It also demonstrates the cross-sectoral nature of their work, indicating that ADPs may share learning across their members in order to make implementation decisions. Other ADP members also reported perceiving value in colleagues' professional opinions:

"Personally, myself, I find it more helpful to have discussions with people, what worked, what didn't work. If you were doing it again, what would you do kind of thing?" (LA2, ADP Member)

"I suppose informal contacts with the managers in particular. I still know a few [service] workers and I tend to listen to their news quite a lot although I don't actually directly ask them the questions but you bump into people. You know and you get impressions and quite often they carry a lot of weight. The things that people say to you informally...you know, 'we'd manage fine if you gave us a third of the value of those six beds, we could deal with all of those clients'. That didn't happen at the meeting it's not minuted anywhere, but actually when we have to make the cuts... yeah that's a source of information." (LA1, ADP Member)

In the latter quotation above, it is suggested that this interviewee's professional background in service delivery continues to influence how they identify and assess evidence. Additionally, this person was currently involved in commissioning for the ADP, and the quotation suggests the 'impressions' from service providers may be influencing this aspect of their implementation work. In particular, informing their thinking about how they can feasibly make local services cuts in the context of broader ADP budget cuts (Chapter 2), suggesting that this type of professional expertise may help implementers make tough decisions for which more formal or documented evidence may not be available. Drawing on professional expertise also emerged as important in the context of ongoing health and social care integration. For example, the below quotation refers to one interviewee's experiences developing a relapse prevention programme in the context of this integration:

"I strongly believe in a bottom-up approach, [we] had a number of staff events, and we used, it was called appreciative inquiry ... this is about bringing two cultures together, this is about bringing all of the interventions together...But at these events, what we did was gauge from the staff what worked for them, how they would like to take [the programme] forward, how we as a management team

could steer it forward, we just took ideas and it was borne out of that.” (LA2, ADP Member)

Alongside showing uses of experiential evidence, the quotations above begin to indicate the personalised nature of evidence assessment and use. In addition to the quotations above, there were instances in the data of where an individual interviewees’ background influenced their relationship with evidence. In the below quotation the interviewee was asked about the persuasiveness of ‘recovery’ as a priority within the ADP’s work, and they referred to their own experiential knowledge which stemmed from their previous role:

“I suppose it’s probably linked to my previous job... I think it was my knowledge of addiction issues from that role and my experiences of working with young women” (LA2, ADP Member)

These excerpts suggest that ADP members bring their own backgrounds (including professional and personal norms, values and ideas) into their relationship with evidence, and that this may influence their perceptions of different types of evidence. Finding that people’s professional backgrounds inform their relationship with evidence is not unusual (Bartley, 1992) and broadly reflects the assumption underpinning Lorenc and colleagues’ (2014) work in exploring evidence preferences of health actors and non-health actors. However, the partnership context of ADPs perhaps means that members’ variable professional backgrounds are informing a wider range of approaches to evidence than would be the case for non-partnership organisations. An obvious example was health, police, or social work representatives primarily reported drawing from their own health-, crime-, or child protection-related data, respectively.

This diversity was recognised explicitly by one interviewee in LA1, who had discussed how their own background led them to seek academic evidence, but reflected that other ADP members had different approaches which led them to rely on other types or sources of evidence (including relying on ‘instinct’):

“I think because the Alcohol and Drug Partnership is a group of people who don’t, you know, they’ve got various strategic leads and a lot of them, it isn’t a drug and alcohol lead, so the head of police, their role isn’t drug- and alcohol-specific, I think they are relying more on stories and gut and all those things rather than thinking ‘well I’ll read some evidence on this’... ‘cause this isn’t their day job so to speak, they would be going on their gut instinct

of what they feel is right. Based on their perspective.” (LA1, ADP Member)

This quotation suggests some interviewees felt their ADP colleagues were drawing upon instinct rather than external/explicit evidence, particularly where their usual organisational role was not specifically focused on alcohol. The references to ‘gut instinct’ might be conceptualised in terms of the use of tacit or intuitive knowledge in local alcohol policy implementation – knowledge which is embodied, rather than external (Freeman and Sturdy, 2014; Gabbay and le May, 2004; Greenhalgh, 2002). As such, the references to ‘instinct’ reflected broader and internalised norms and frames of reference which were not expressed explicitly in everyday work of the interviewees. This contributed to ADPs’ culture of evidence, however I note that, across the data, most ADP members appeared to be drawing to some extent on both embodied and external sources of evidence to inform their implementation work.

Another type of experiential evidence - feedback from service users - was a particularly meaningful type of evidence to some ADP members (especially in LA1 and LA2). Members of the ADP coordination teams in particular spoke about the importance of obtaining service user feedback, for example:

“[Service user feedback] makes it much richer as a result. ... we’ve done a lot of ‘conversation cafés’ where people in recovery have come together with other professionals and talked about what they want to see happening in their local community, and how we will make it happen. Those stories are really helpful because, if I’m honest, sometimes you learn something new there, something comes up and that’s great. A lot of the time you’re hearing what you already know but it inspires you to do something, it gives you the motivation to do it, because suddenly you’ve got people in recovery sitting there saying ‘we’d like to work in our treatment, we’d like to volunteer in our treatment services’ and you’re thinking, ‘yeah we know we need peer workers in our treatment services’. And when you hear that you think ‘right, there are people out there who want to do it, let’s do it’. So it’s a motivator to get it going.” (LA1, ADP Member)

“We were really keen to hear [service users’] thoughts in terms of what did it feel like to be in recovery from addiction, and what were services were doing or not doing, what was the ADP doing or not doing, what was [LA2] as a whole doing or not doing in terms of supporting recovery?” (LA2, ADP Member)

As noted in Chapter 5, involvement of 'peer' service users was a focus of the included ADPs' partnership work - these data suggest service users are also playing a key (and potentially growing) role in providing evidence to implementers of Scotland's alcohol strategy. In particular, these quotations suggest that ADP members seek to understand the perspectives of service users and use this to inform their priority-setting and decision-making for implementation. This suggests ADP members may seek to balance, or consider in tandem, priorities as named in the national alcohol strategy and community-identified needs. This adds to the complexity of the implementation work they engage in, given these priorities may not necessarily align and could end up competing for local implementers' time and resources.

However, available guidance for ADPs does encourage them to make decisions, at an organisational level, in consideration of locally-identified needs. For example, ADPs are encouraged to undertake or commission 'local needs assessments'⁵⁵ which help assess the extent of service needs and gaps. In particular, the *Updated Guidance for Alcohol and Drugs Partnerships* (COSLA et al., 2015) links funding and evidence use, with explicit mention of needs assessments:

"[funding] is a partnership resource and the full allocation must be directed to ADP level for decision-making informed by robust needs assessment and in line with recognised evidence base."

Interviewees in all three local areas referenced their needs assessment in interviews; assessments seemed to provide a key source of evidence to inform ADPs' service delivery decisions and potentially fulfil national expectations of evidence use and locally-identified needs.

When locally-relevant evidence was unavailable to support implementation decision-making, there were limited, but meaningful examples of ADP members overcoming the lack of evidence observed by creating evidence themselves, by conducting research in their organisation or synthesising existing information. This was

⁵⁵ Local Needs Assessments are strategic, structured assessments to "[identify] the needs of the local population, so that services can be planned and delivered to meet those needs]" (Scottish Executive, 2004, p. 1). They often include data generated from service users, or their representatives, families or carers, as well as service providers. They are therefore an important, structured way in which service user perspectives are accessed.

particularly evident in LA2 and LA3, where members of the ADP reported structured information gathering to assess service user or broader public perspectives on a particular issue. For example, in LA2 an interviewee spoke about the lack of available evidence on barriers that women face to accessing addiction services and the solution the ADP developed to address this:

“there really wasn’t anything that was kind of current or pertinent to us, there wasn’t an awful lot of availability of evidence [on barriers to women accessing services] [...] that’s why we did the peer research, and for us, I suppose it was twofold in terms of the outcomes for that. We got the evidence to hopefully try and move forward, but we also were able to train up the peers in delivering that research and increase their capacity and confidence and skills and everything.” (LA2, ADP Member)

This interviewee described instituting a new organisation-level tool for developing needed, context-specific evidence which incorporated experiential types from service users (‘peers’). This approach appeared to increase both the capacity of the ADP as an organisation to generate and use evidence, and the capacity of people in recovery. However, this was a single instance in this ADP, and it was not clear whether this ADP was being supported to continue this type of internal research work to inform implementation. In LA3, there was another instance of the ADP gathering their own evidence to access public perspectives:

“We went out and did some public survey work, we spoke to people, I think we asked...over a thousand people about their views, and one of the questions we asked was around licensing, ‘do you believe there’s enough licensed premises?’ Or something like that, in [LA3], and overwhelmingly the public think there are, and don’t feel there needs to be any more, so we had that information.” (LA3, ADP Member)

In addition to demonstrating locally-generated evidence is a privileged source of information within ADPs, this again suggests ADP members are concerned with understanding local perspectives. Data from another ADP member supports this, exemplifying data in which interviewees were explicit about trying to access, and respond to, needs identified by their local community:

“Within our local policing plans, I think probably all our local authorities have got alcohol and substance misuse as a priority... Within that we’re laying out our kind of commitment to addressing issues roundabout alcohol misuse within that. Because the communities have told us that’s an important issue for them.” (LA3, ADP Member)

These data indicate that uses of evidence to assess public perspectives about local alcohol issues may be closely linked with the idea of 'participatory accountability' discussed in Chapter 5. Having gained an understanding of these public perspectives, members of ADPs seek to act upon this evidence given their apparent sense of responsibility to their local community. Further, that experiential types of evidence (both intuitive and gleaned from professionals and/or service users) influence priorities and decisions in alcohol policy implementation. These findings provide initial indications of ADPs' culture of evidence, one which assesses evidence based on ADP members' needs, and a preference for evidence which is sufficiently contextualised and actionable.

Shifting to focus on another type of evidence, ADP members referred to quantitative evidence as important. The below quotations illustrate ADP members' perceptions of quantitative evidence, including recognition of its' limitations:

"The ISD data may be a little bit out of sync with what you know locally, but you kind of just have to live with it, you just have to make the best of what you're getting. The data has improved enormously over the years" (LA3, ADP Member)

"if I need a piece of information as I said with the recent budget setting, and looking at risk assessments, some of the quality impact reviews, we could draw on stats and information, to be able to make informed decisions" (LA2, ADP Member)

"the way I look at it is there's a place for the data and the stats, it has to be, you know there has to be an educated approach to it, there's no point in just throwing money, resources, at a project, there has to be some sort of theory behind it as well." (LA2, ADP Member)

The above quotations suggest ADP members are regularly using quantitative evidence. The interviewees indicated this type of evidence could be particularly useful in helping ADP members to measure progress against key local indicators (a component of their role identified as important for accountability reasons, see Chapter 5). Interviewees reported the quantitative data they used was often collected across Scotland or local areas. Locally, the above-mentioned local needs assessments can also include quantitative data – for example in LA1 a needs assessment drew upon questionnaires and surveys, in addition to qualitative methods.

As a qualifier to the above, however, some interviewees reported a need to interpret quantitative data to make it more useful. This appears to occur when the quantitative evidence (e.g. statistics) aligns with an individual's experiential understandings, and if it is being used to prompt thinking about what can be actioned in response to the statistics:

"I can get the stats out to show you that, but I know that 'cause I work in the area. So although I could talk to that, I could still evidence it. So it's that wee bit about saying to people, I know what works, right, and I can back it up. But it's about knowing where your field of expertise stops. It's about knowing where that stops and you'll need to go and ask other people. We've got a system called [redacted], so I can go in and download fast statistics...But stats are only numbers. How I interpret the stats and how I evidence what I do, but the stats is the difference. When we do a report, what I would say to somebody is, pull down the stats and see what your hotspots are and then tell me what you're doing about it. So tell me what you're doing about it is the difference." (LA2, ADP Member)

Overall, it appears that ADPs' organisational-level culture of evidence includes a range of different types of evidence that can be perceived as useful in the context of their alcohol policy implementation work. With respect to this characteristic, ADPs appear to generally use an eclectic mix of evidence types depending on their needs, but with a striking emphasis on experiential evidence, and with some notable diversity arising from tacit knowledge they bring to this work.

Turning to focus more closely on *sources* of evidence ADP interviewees reported drawing upon, these are clearly very closely linked with the types of evidence discussed above. Common sources appeared to be health organisations, other local organisations (e.g. local Councils or Heath Boards) and academia. ADP members broadly discussed academic research as a potential source of evidence (most often to say they likely should be using this source more). In particular, resources which synthesised available research evidence were perceived to be valuable:

"There is some, some evidence and it's very well collated through Drug and Alcohol Findings [website], which is my absolute bible for everything and occasionally you can just email [website creator] and say 'I don't know this, tell me' and he tells you and it's great" (LA1, ADP Member)

Given that policy implementers do not have time set aside in their workday to engage broadly with available evidence (despite national expectations to use evidence), this type of resource seemed to assist individuals in understanding available research. Another ADP member reported how useful academic research was when it was specific to Scotland:

“... the international stuff which is great. But it is much more helpful to have stuff like Niamh and Jamie’s⁵⁶ work to be able to say look this is Scottish data.” (LA1, ADP Member)

However, certain interviewees expressed frustration with academic research. For example, interviewees reported feeling that academic research often did not help them address the particular problem with which they were grappling:

“So how many alcohol detox beds do we need? ... Who knows? There isn’t really a formula, and even if you look in the international literature, everywhere it is arranged differently. You don’t really know, and academic articles don’t usually spell out exactly what the treatment system in general is in that area.” (LA1, ADP Member)

A similar frustration was expressed with regards to ADPs’ capacity to act upon research to pursue preventive approaches. Alcohol research, similar to broader public health literature, consistently recommends prioritising prevention (e.g. Groves, 2010; World Economic Forum and World Health Organization, 2011). In the *Framework for Action*, the Scottish Government followed this evidence, indicated: “We are committed to taking action now through legislative change and a record investment in prevention treatment and services” (Scottish Government, 2009a, p. 5). However, ADP members spoke in-depth about the difficulties in acting upon this evidence and related policy imperative because of constrained resources. For example:

“yes we need that whole population approach, but we need additional resources, because the whole population approach, assuming it works, will have that long term preventative impact. So we can’t afford not to have that, but right now we also need, additionally [to] focus on people with very specific and high level needs. So it’s about actually, for a period, needing to do both. [...]

⁵⁶ Interviewee is referring to research conducted by Dr Niamh Shortt and Professor Jamie Pearce, from the Centre for Research on Environment, Society and Health (CRESH) (www.cresh.org.uk). Dr Shortt and Professor Pearce conduct research related to alcohol policy in Scotland, the UK, and internationally.

But when you come to then say 'oh and by the way we need resources for prevention' and when those resources are finite [funders] are saying 'okay well where should we take them from then'. And the reality is we can't take them from the highest levels of need because they are screaming out for services" (LA1, ADP Member)

As another example, one ADP member expressed their frustration with research evidence in terms of what were identified as its 'biases', and what these meant for its relevance to their work:

"...the biases in the evidence base, which make it very problematic... [individual interventions are] the things that are evidenced, that are researched. Social changes, employment, the impact of your community, the impact of having a strong relationship with family members, isn't, because the research is based on who does the research, and the research is done by the people who sell methadone...so simply to follow the evidence base by what has a large number of research papers supporting it as an intervention wouldn't work for running a treatment system. It would say 'we have to do an enormous amount of CBT [cognitive behavioural therapy], we have to give out methadone, we have to use motivational interviewing' and it would exclude some really fundamentally good things that we do, like wrap-around services that we need, trying to develop recovery communities, enabling people to access mutual aid, a whole string of things that are under-researched. So we always have to take sort of a nuanced view of that because we tend to get doctors and psychologists coming in and saying what you need to do is spend *all* of your investment on *this* exact piece of CBT. And I know that successions of CBT isn't necessarily going to work and no amount of evidence is going to convince me that it will to be honest." (LA1, ADP Member)

Somewhat in contrast to the data regarding prevention above, from this interviewee's perspective academic research is typically too focused on individual interventions to the exclusion of researching upstream socioeconomic factors (which would need to be taken into account when making local alcohol policy implementation decisions). Consequently, despite the culture within my three ADPs appearing to be generally open to a wide range of evidence, the data also suggest some types and sources of evidence, notably academic evidence, were sometimes perceived to be not well-suited to alcohol policy implementation decisions locally (because, for various reasons, they could not be acted upon).

Alongside these critiques, further data suggested resistance to research evidence among some ADP members. For example, there was a contrast between the national level expectations about using research evidence and a sense among some ADP members that research was already overly influential and ought to be rebalanced by a stronger focus on people's experiences. For example:

"I think working in a health system, sometimes that's problematic because the whole culture of the health system is you've got a whole group of professionals who are the experts in what they do, and of course they are and they're highly trained, etc. But I don't think we're good at turning that round and putting the experience of individuals who've been through recovery at the heart of what we do. We still work on what the research says and what the policy says and what the guidelines say, and actually if we did much more of the, but what do people who've been through it actually say and we tailor what we do to that, I think we'd be much better at what we do." (LA3, ADP Member)

Additionally, interviewees in different local areas expressed a need for viewing and interpreting evidence (particularly academic research) in a nuanced, context-sensitive way:

"you get these very broad general, sort of, sweeping statements about the evidence. And it doesn't really get challenged. And I see that as really unhealthy, because I think it's almost put to people that, as though that's a truth. You know, that's a, kind of, accepted truth and because it appeared in a systematic review or whatever then it can't be questioned. Whereas I think... it's a lot more complicated than that. And it's, kind of, shades of grey rather than black or white stories." (LA3, ADP Member)

This quotation, which informed the chapter title, helps characterise the data presented here, indicating that a broad culture of evidence surrounding ADPs can be identified - in terms of valuing different types of evidence, finding a range of different evidence sources credible, and seeking evidence which is presented in a way that is context specific and actionable.

In sum, ADPs appeared to have a relatively open and eclectic 'culture of evidence' but evidence was more likely to be used if it met the following criteria: (i) it was perceived to address specific questions/problems the ADP was dealing with; (ii) it was Scottish-specific or acknowledged constraints implementers were under; (iii) it was informed by local perspectives; and (iv) it felt credible (e.g. because it fitted with members' experiential accounts or their 'gut' feelings). Despite the sense of

openness to different types and sources of evidence, academic evidence was highlighted as having limitations since it was perceived to rarely meet such criteria.

‘Real’, powerful, and contextualised: ADP perceptions of effective presentation of evidence

This subsection builds on the results above. Given the emphasis placed on experiential evidence, it is perhaps unsurprising that some ADP members suggested hearing about experiences directly from those affected was a particularly powerful way of evidence being presented. For example,

“The workforce development session we had ... one of the most powerful inputs I thought from that was the modern apprentice who was in. She was talking about mental health, and problems particularly with teenagers and mental health, and I thought that was fantastic... she was very honest and very open and she spoke about her own experiences, and I loved her quote about you know if I broke my leg you wouldn't expect me to walk about for 6 weeks with a broken leg, and yet I have to wait for 6 weeks if my mind is broken, I thought that was fantastic. So I think, inputs like that and from people like that, I think are far more lasting and far more powerful...It's somebody, it's not somebody speaking in statistics or shooting PowerPoints or pie charts, it's about actual real life you know...these are people who've been through it and know what they're talking about, I think there has to be a bit of credibility behind it” (LA2, ADP Member)

This suggests that evidence which was about ‘real life’ was more valuable and interesting than quantitative data, highlighting how this ADP interviewee gives credibility to a person with lived experience of engaging with services, and that this evidence had been presented in an engaging, powerful way which was perceived as relevant and meaningful to this person’s work.

A key observation about presentation, in terms of ADP members’ culture of evidence, was the need for evidence to be provided in a way which was sensitive to the context in which it would be used. This helps reiterate the results presented above, and suggest evidence needs to be relevant to ADPs’ policy work and ‘actionable’ given the constraints (e.g. in terms of resources) of ADPs’ work. With respect to presentation, ADP members were critical of research which did not provide clear, practical guidance. For example, one ADP member expressed frustration with academics who s/he perceived to be producing research that

reflected the researchers' lack of experience actually delivering the services (e.g. ABIs) they were writing about, often concluding there was a need for future research but not providing clear, actionable ways forward:

"it gets a bit tiresome sometimes reading things that very often conclude that there's a need for further research... the amount of investment time and investment that goes in to academic research, I think people expect a bit more from it, a bit more in terms of clarity and more of a, sort of, guide in terms of how it can be put in to practice...in terms of credibility, you can pick up quite easily when people don't actually have experience in an area that they're talking about." (LA3, ADP Member)

Thus, ADP members seemed to value evidence which had not only been undertaken in a way that was sensitive to context, but was also presented with the same sensitivity. They expressed further frustration with having evidence they perceived could not be 'actioned' or ignored the research needs of local implementers. The quotations below illustrate these frustrations further, as local policy implementers shared the challenges they faced when trying to use evidence, particularly academic research:

"I suspect if you're a researcher you're kind of going 'well I'm going to learn all of this stuff because I'm going to tell people, and then the people that I tell are going to change things'. But nobody's asking what we'd like to know...We have a research project currently going on...[about] whether putting a senior social worker in a GP's practice improved outcomes for clients. There is absolutely nothing more useless than knowing that if I had another £5 million I could put somebody (bangs table) who costs £40,000 a year into every one of our GPs' surgeries, that's lovely, I'm sure it did, but (laughing), why? Why find that out? You know, yeah, so ask some questions that we might be able to action. (LA1, ADP Member)

This quotation suggests a key difficulty faced by ADP members is interacting with evidence which does not include recognition of the constraints they are under, which require trade-offs between what will work and what is feasible in terms of resources. This again emphasises the importance of usability or 'actionability' of evidence as discussed in the subsection above, this time in relation to what the evidence is focused on (or neglects – with the above quotation suggesting a lack of attention to resources). The quotation above also touches upon a number of other challenges discussed by ADP members, including a perceived 'gulf' between evidence (most

often academic research) and policy. When I asked how this challenge might be addressed, the same interviewee responded:

“[researchers asking] what are our problems... Our problems would be what would improve outcomes... what would improve efficiency, and something about evidence-based commissioning... if people asked us what we wanted, and that’s not what happens it’s the opposite of what happens.” (LA1, ADP Member)

A colleague of theirs helped to confirm this:

“if you narrow the gulf between research and policy makers...actually having them directly interacting, I think it’s very helpful.” (LA1, ADP Member, NHS)

The quotations above suggest a need for research-policy engagement and co-production, particularly to improve key processes within alcohol policy implementation (i.e. undertaking commissioning). The data suggest the content of available evidence is currently too remote from the realities of local alcohol policy implementation work, and is therefore difficult to use. Again, evidence was less likely to be perceived as persuasive or as having value if it was not sensitive to the context in which Scottish alcohol policy implementers were working (e.g. one characterised by resource constraints). Instead, it appeared ADP members perceived additional, locally-focused evidence would be useful:

“We just need small, simple independent bits of research on an ongoing basis with some consistency to them, that would help us” (LA1, ADP Member)

This section has been focusing ADP members’ evidence use in their own work to implement Scotland’s alcohol strategy. However, interviewees also richly discussed using evidence to try to influence other alcohol policy stakeholders.

“Knitting them all together to paint a picture”: Evidence as a tool to persuade or justify decisions

The data also demonstrate ways in which ADP members use evidence as a tool to persuade, both within the ADP to inform or influence each other in their partnership-working context, and to persuade other alcohol policy implementation stakeholders outside the ADP. The individuals or organisations ADPs appeared to be trying to

persuade often included LBs (although this may have been a result of my interview approach), as well as others in local or Scottish government.

First, ADP interviewees indicated the persuasiveness of evidence for use within their partnerships could be enhanced by integrating different types of evidence. For example, one interviewee from LA3 described bringing ‘the evidence’ together relating to alcohol and social marketing in order to make an organisational-level decision. When asked what this entailed, s/he described:

“[we] would have done some kind of review of what the literature said around social marketing and alcohol and we’ll have taken that and put it into a case... [we] would have taken information from the needs assessment, we would have taken information at the morbidity mortality statistics, alcohol admissions to hospital, and just again built a picture, bringing all that in together and building a bit of a picture around it. And then presenting that as, ‘here’s the evidence behind it, here’s what our aim is, here’s what we’re proposing to do and here’s how much it’s going to cost’...and getting that signed off by the partnership.” (LA3, ADP Member)

The quotation above also suggests an important component of ADPs’ work was to play a translational role in relation to evidence, for informing ADPs’ decision-making:

“Part of my role is actually...drawing on published research or the literature is being able to translate that into a meaningful context for local use, it’s not always necessarily easily understandable or readable. So yeah, so it’s being able to pull key messages and distil that down to the local context.” (LA3, ADP Member)

These quotations suggest ADP members were reflective about their role in evidence translation and that this role was not a passive one – they were explicit that this was done in an effort to influence decision-making. This translation responsibility fell to the core ADP administrative team. However, when attempting to influence others (an issue to which this section will now turn), ADP members more broadly appeared to have a role to play in translating and synthesising evidence to persuade LBs and others in local government.

This persuasion role of ADP members emerged as a distinct aspect of the culture of evidence of these partnerships. The translation role they play, noted above, was also evident in this context:

“I am filtering the research through my lens in order to get the policy-makers to make the kind of decisions that I am recommending to them” (LA1, ADP Member)

This interviewee appears to be conscious that they are filtering research through their own perspective. ADP members seemed to also be reflective about the differences between their own uses of evidence for individual decision-making, and the more performative aspects of using evidence in ways they perceived to be required by their target audience – i.e. their own organisation or policy actors they were trying to influence. This was expanded upon further by another ADP member, who described using an approach which ‘knitted together’ sources of evidence to develop a targeted and persuasive argument:

“we’ve done a lot of work to present the evidence around alcohol and alcohol brief interventions, and we would use local information...we’d use information about alcohol related admissions to hospital and things like that, we’d look at some of the morbidity and mortality statistics around alcohol. So it’s about taking the information that we have available along with the national policy and guidance that comes along, along with the local situation and just knitting them all together to paint a picture for people about why it’s important, why it’s important to them...” (LA3, ADP Member)

Interview data provided further insight into what types of evidence ADP members thought would be persuasive for this purpose, although there were different perspectives among them. Remembering that ADP members reported finding experiential evidence was often persuasive to them in their own work, by contrast some ADP interviewees reported that, to be persuasive to others (such as LBs or others in local government), evidence needed to be ‘real evidence’. In this context this seemed to mean evidence which had been collected systematically and was quantitative:

Interviewee: If you talk with belief and conviction but don’t back it up with real evidence then that’s when it’s easier for people who don’t really want to hear the argument to dismiss it so we really are dependent on some very cutting facts I suppose in terms of how we are trying to put our argument together...we just need to keep making that argument in a coherent and cogent way not just in an emotive kind of way I suppose.

AW: What do you mean by ‘real’ data when you say that, what types of information are you saying are going to be most persuasive?

Interviewee: Well I suppose anything that is evidence-based really, so fact and figures and numbers, rather than, you know “we know that it makes a difference”. We actually need to use, we need to use hard data as opposed to, to logical argument.” (LA1, ADP member)

This exchange suggests that quantitative data is perceived as ‘real evidence’ when it comes to persuading others, while argument based on experience is not. This person goes on to place this in the context of needing to make implementation decisions which get best value for money:

“I suppose if what we are going to do is use our resources to absolute best effect we need to understand better what that best effect is and how its achieved and I am not sure we necessarily do with that very well....And [service user feedback is] different from hard data and it’s much softer and it’s probably more difficult to capture in a sense, but it probably would be, if not as, I mean it’s not as compelling in terms of the kind of arguments that I have described earlier, so what is compelling for people is just to have it straight, you know, X number of these Y number of those extra, because that is very powerful.” (LA1, ADP Member)

These quotations exemplify how some ADP members spoke about justifying decisions to others in government, or providing persuasive evidence to or LB members. Yet, a police representative from the same local area helped explain why this approach, in a licensing context, may still be fraught with challenges:

“if we’re going to evidence something, hard, solid facts, saying that something might lead to an increase in crime and disorder doesn’t really do anything of the Board, they prefer to...get that the concrete facts, evidence that something has led to something. So really, crime stats... might not be persuasive enough. What I’ve found what’s not really to our favour is they look at a 250m radius from the proposed premises, but if you actually work out crime stats for a 250m radius of premises, you wouldn’t actually get that many crimes. Whereas if you were looking at a bigger radius then you would get a truer picture. But sometimes you’ll object to a new premises and they’ll ask for an analytical report, so we’ll ask our analysts to do a crime and anti-social behaviour report, and it works out to be two crimes every week. So it doesn’t actually look that bad. And you know it’s a hotspot for police officers.” (LA1, ADP Member)

This quotation suggests that, while LB members may request locally-contextualised data it is difficult to present numerical data which illustrates the significance of the problem on such small scales. Meanwhile, a different ADP member from LA1 expressed a contrasting perspective to those above, emphasising their sense that it

was sometimes 'stories' or more experiential evidence that worked to persuade LB members:

"when [LB members] hear stories it means something to them, much much more. So it gets a bit complicated when you try to explain rates per 10,000 and all the rest of it but actually, we've had stories from colleagues who work in the alcohol-related brain disease unit and things like that, people coming in with those sorts of stories have far more impact than we've had setting out some of the data. Police talking about how they, what's happening in the night-time economy, those sorts of stories. Various members of the Forum and the Board have in the past been out with the police sergeant out on a Friday or Saturday night to see what's happening in the city as well so there's those sorts of stories, those sorts of personal experiences have been really quite helpful. But we need to do more of it, because it feels like that works more than, well it works probably alongside data rather than just as we've done in the past, bang down data and people have questions. And once you get into a detailed discussion about data you know you're onto a loser, because half the people have switched off." (LA1, ADP Member)

This helps illustrate that even within a given ADP there are different perspectives about what evidence might be most useful in interactions with other alcohol policy stakeholders such as LBs. This interviewee sees an important role for experiential evidence to engage their audience. However, another ADP member, while saying they personally valued evidence from service users, reported they could not use this type of evidence to justify a local decision to others (e.g. local governance actors to whom they are accountable, or other alcohol policy stakeholders):

"We do conversation cafes where we meet with clients... The first few times we did them they were amazing, 'cause even, you know I, I now sit in an office, removed from treatment services and even when you see the treatment services you're in quite a structured formal conversation with people a lot of the time. And the conversation cafes where people were just coming and talking about their experience and jumbling up professionals with people in long-term recovery with current clients. And just throwing them together was amazing. I mean it was astonishing how much you could discover. That offered a lot of insight into the treatment system... So that's a real source of information that's great but you couldn't make a major investment decision based on it because you can't, 'I chatted to four blokes at [Name] Cafe and they all thought it was a good idea'. Now that might actually convince me it was a good idea but I, it wouldn't stand up for me to spend money on the strength of it." (LA1, ADP Member)

“at the end of the day if its informal stories that’s okay for me but does it move the world on, you know, in terms of its legitimacy and so, if we had bodies of research...I am not an expert in all of that but something that would then lend it weight in academic terms or that we could say this is a genuine piece of work that we can base our decisions on in terms of service development, because that is necessary to justify facts and figures.” (LA1, ADP Member)

The quotations above illustrate differences between evidence used by ADP members to make their own decisions or persuade partnership members, and evidence they used to persuade others or justify decisions beyond the partnership. The ADP members quoted above also appeared to be using evidence somewhat defensively; using evidence they perceived as credible to their target audiences (to whom they may also be accountable) in ways to pre-empt and prevent possible criticism. I reflect, however, that the quotations above were from core ADP team members, and this apparent sensitivity to scrutiny was less evident among ADP members beyond the core team.

Consistent with findings across this chapter, the work of ADPs to influence others was happening in the context of partnership working. There was some evidence ADPs tried to capitalise on their partnership structure to influence LBs. For example, a police stakeholder from LA1 provides more insight to this by describing working with colleagues to provide a detailed objection to an alcohol licence application supported by multiple sources of evidence:

“in terms of how we frame objections to licensing applications, it will be around some of that research that’s been done linking outlet density with crime and disorder. And we’ll quote some of those pieces of research, and we’ll also provide crime stats, so that’s where [NHS representative] comes in because [s/he] can provide some of the health stats as well, so what we tend to do is if we’re going to object to applications, [s/he] would object on the basis of the health information and I would provide more crime and anti-social behaviour, information. And then see how we get on. Unfortunately, a lot of our objections haven’t met with much success, and the Board have granted applications that we’ve objected to for whatever reason...in terms of the grounds for those decisions, sometimes lawyers quote economic reasons, employment, and all of those reasons. Whilst it might be a factor in the decision-making, it shouldn’t really be because they should be basing decisions on the Licensing Objectives and the legislation. So that’s sometimes a frustration.” (LA1, Police)

The interviewee suggests their collaborative approach with local partners to combine evidence had not been successful because ultimately the LB was concerned with economic factors (a key concern noted in Chapter 6). Considering this further in context, LA1 also did not have a strong overprovision statement and all LBs have autonomy to interpret evidence flexibly (also noted in Chapter 6). It appears that, despite partners working together to combine evidence to support objections to licence applications, it was difficult to overcome the determination of this LB to consider the local economy, and that in this way the public health objective was again limited in its ability to achieve public health goals. Another quotation from LA1 illustrates this issue further:

“I did a huge piece of work on the overprovision statement, researching right back to the original evidence...we did a great deal of work...it’s impeccably researched, it presents a very logical argument that goes from there is harm, we know that consumption is linked to harm we know that provision, consumption is linked to availability, ergo you will reduce harm, and it was impeccably argued from beginning to end, fully cited, (pause) absolutely ignored. They took no notice whatsoever.” (LA1, ADP Member)

These quotations provide an example in alcohol policy implementation of a decision space in which the two organisational cultures of evidence interact, and begins to illustrate differences between them. Ultimately, some ADP interviewees expressed a sense of futility and frustration following efforts to persuade others, in particular the LB, where quality and weight of combined evidence do not seem to overcome economic considerations. LBs’ own culture of evidence and their perspectives on evidence provided by ADPs, are discussed in the next results section (Section 7.2.2).

To summarise, the data suggest an organisational level culture of evidence surrounding ADP members can be identified. Broadly conceptualised, it appears that ADP members are working within a policy and partnership context in local governance, in which they evaluate the value and persuasiveness of different evidence in terms of its fit with their own evidence needs and/or how well it can help them persuade other alcohol policy implementation stakeholders. Additionally, they report using a wide variety of evidence, but that this occurs in an environment which has important resource constraints (and thus requires difficult prioritisation decisions). While it was possible to identify an organisational ‘culture of evidence’

across the case study ADPs, this incorporated diversity in how individual ADP members perceived and used different types and sources of evidence, which reflected the fact that ADPs bring varied organisations into partnership. Regarding using evidence to persuade others, the data has suggested that ADP members had their own opinions about what type(s) of evidence will be most persuasive to LBs or local government actors - i.e. either experiential or quantitative evidence - but often ended up using a mixture of both, a potentially pragmatic and strategic choice. This seemingly was in an effort to anticipate if individuals in LBs may have different evidence preferences, or to try to overcome LBs' consideration of economic factors in their licensing decisions. These findings, however, remain limited by being based on ADP members' perceptions of LB preferences – the next results section examines what LB members themselves report.

7.2.2 “We’re the ones that make the decisions”: Licensing Boards’ Culture of Evidence

Correspondingly to ADPs, the data in this section will show that it was possible to identify a culture of evidence within LBs, albeit one that involved diversity in members' perspectives on evidence. As a reminder to the reader, LBs are operating in a quasi-judicial capacity, in which their decisions are only challengeable through an appeals process (see Chapters 2 and 6); this legal context helps differentiate their culture of evidence from that of ADPs. To describe LBs' culture of evidence, the below subsections again organise the data into types and sources of evidence, and then presentation of evidence.

“Facts and judgement”: Using different types and sources of evidence in a licensing context

When asked about evidence use, LB interviewees most often reported using evidence contained within the package of licensing application documentation, which is provided to them for their monthly licensing meeting and is comprised of different types of evidence⁵⁷. This documentation package is compiled and provided by the LB Clerks, and contains the specific individual or premises licence applications to be discussed at the meeting. It also includes any relevant notes (e.g.

⁵⁷ Although note, they also receive evidence for other decisions such as for informing the development of their Licensing Policy Statement.

“information of how many [licences] there are in a certain area” [LA2, LB Member]) or objections. Objections may be included from the public or statutory organisations who are permitted to submit comments and related evidence (health and police rather than ADPs as a whole). The below quotations help illustrate LB members’ perceptions that evidence within the documentation package was a core part of the licensing decision-making process:

“The licensing applications are straightforward, there’ll be police reports basically saying, you know, they’re alright with this, the ones that have objections...we get to see the police reports that’re not made public [...] On the wider front, the ones for licensed premises, again I’ll look at the reports and we will get maps of how many different licensed premises there are in that area.” (LA1, LB Member)

“We will get a set of papers which will have a cover sheet...then there would be supporting documentation from Police Scotland, perhaps giving their concerns and...sometimes there may be other people, other departments, putting in their concerns too, from building controls, the licensing standards people, there could be all sorts of people who have just put in their – if there are complaints from – objections...then those might get listed as well.” (LA1, LB Member)

Given the licensing documentation package is produced specifically for the purposes of the licensing meeting, it appears designed to contain the most specific, focused evidence available to LB members for their decision-making. While evidence may have been provided from a variety of people and departments, this is collated into a recognisable, standardised package for the LB members to read. Hence, the compilation of the package represents a funnelling function occurring in the process of submitting and collating evidence, to ensure the evidence provided to LB members meets the needs and requirements (i.e. legal and regulatory) of the licensing meeting. An additional consideration is that the funnelling and collating of the evidence is also carried out in a political context:

“at each of these committees we’re fed a paper report from officers who’ve written that in two ways, it’s written for what the professional officer wants, and it’s also normally written to meet the priorities of the ruling administration.” (LA1, LB Member)

This suggests that evidence contained within the licensing documentation sometimes serves a strategic function, consistent with existing research which observes that evidence is generated and used in political contexts that influence how this use occurs (Hawkins and Parkhurst, 2016; Liverani et al., 2013). For LB

members, this means their interpretations and uses of evidence may be shaped by local and national politics, especially given they are also elected political actors.

Indeed, nuances can be observed in terms of how the evidence is perceived and used. The below quotation indicates that LB members may 'interrogate' those who have produced the documents, and further interpret the information contained within them:

"You have to listen to the facts on the day and make a decision on the basis of these facts and judgement, and as a result of interrogation of those who are producing the reports, because sometimes they make quite interesting reading, when you actually start probing what's on the reports." (LA1, LB Member)

This suggests that the sources (institutions or individuals) who contribute to producing this evidence for LB members are potentially important influences on how LB members interpret the evidence included in their licensing documentation. Sources of evidence will be discussed in greater detail below (p.XX).

Moving on from the documentation package, types of evidence discussed by LB members included statistics and research, as well as 'stories' or narratives. First, a minority of LB interviewees explicitly reporting using statistical evidence. As an example, one LB member described finding statistics provided to them by the ADP useful:

"I found particularly useful, [the ADP] had the four stats which from memory was something along the lines of alcohol-related admissions to hospital, alcohol-related crime, number of off-licences per head of population and number of on-licences per head of population and in, I think it was six or seven data zones in the city, all four of those indicators were well above average and that rang alarm bells in those four areas... I think there needs to be an ongoing discussion about whether those are the right statistics to look at but I found them particularly useful." (LA1, LB Member)

This LB member seemingly perceives statistics as a useful and credible indicator of where problems may exist in their local area, while expressing an awareness that available statistics' usefulness may be limited. They further indicate that 'right' (or better) statistics may exist (although does not provide further details about what 'right' statistics may entail). The way this same interviewee goes on to caveat their response and refers to the need for ongoing discussion seems grounded in an

awareness that some LB colleagues are more critical of such health-related, population-level statistics:

“Personally I prefer statistics and...academic research however I am aware that other colleagues prefer it the other way around.”
(LA1, LB Member)

This quotation directly acknowledges the diversity of perspectives on evidence among LB members. Another LB interviewee provided a more nuanced view of statistics, in relation to how they are more useful if they can help tell a story:

“The stories in [Licensing] Committee don’t tend to resonate, it’s the statistics, but talking to them outside on a one-to-one basis has a big impact....it depends...the straightforward stats can tell a bigger story. If I can give another example? A real life example. A couple of years ago it was...I was going to say Halloween. It was Halloween. It fell on a Friday night. All these requests came in, ‘we want to extend [our licence] by another two hours’. And the police had provided a report saying that the last time Halloween had fallen on the Friday that the levels of crime rose tremendously ...went stupidly high....So, those stats to me provided enough concern about worrying about crime and disorder. (LA1, LB Member)

This interviewee appears to perceive ‘stories’ as less impactful than statistics or speaking with other LB members directly. However, they indicate that statistics can be valuable for helping to substantiate a narrative about the alcohol-related environment locally, which was useful for licensing members to incorporate into their thinking. Indeed, it appeared that, like ADP members, LB members were more interested in statistics if they could help tell a story about the local context. For example, a LB member from LA1 discussed this type of evidence when describing a conversation s/he had with an NHS representative from the local Health Board and ADP:

“If it was about the real impact locally, you know and real life stories, would impact more. And maybe giving regular updates that there were X amounts of people went through A&E with alcohol-related illnesses or deaths in the last 6 months, in your ward. That’s a hard stat for me. You know, that’s a hard thing to, ‘cause it’s a fact. It’s not just somebody coming to the Licensing Board with scaremongering, getting a fact, there are X amount of people died in your ward this month, this year, because of alcohol, and that I think is the real, kind of the, practical real life stories that councillors need to hear. Because the policy’s just documents on the shelf and we’ve got professionals officers and health and solicitors whose job it is to know what these policies say. But we’re the ones that make the decisions.” (LA1, LB Member)

This quotation suggests this LB member wanted to be provided with information they perceived as relevant to their local area and the license decision they needed to make. It also shows a clear understanding that LB members have responsibility for making decisions in this licensing context, which distinguishes them from other local officials (i.e. ADP members).

I turn now to focus on the *sources* of evidence LBs discussed – these individuals or organisations may contribute evidence to the licensing documentation package described previously or provide it in other ways (e.g. during Licensing Policy Statement consultation). First, several preferred sources of evidence appeared to be first-hand accounts or discussions which were part of the licensing decision-making process on the day of the licensing meeting, or processes directly associated with it. This included discussion with colleagues, site visits to premises, and listening to members of the public (either as applicants or objectors), all of which appeared to be common mechanisms for LB members to obtain information in the course of their decision-making. The below quotations illustrate these particular different sources, and indicate how these sources are considered within the legal context of a licensing meeting:

“We usually have a pre-meeting. And we talk over... looking at legal points and then kind of talk over with this, and then we make a decision on the day [...] Sometimes when it’s a place that we don’t know, that’s why we go on site visits...the premises gives you a better insight” (LA2, LB Member)

“I genuinely listen to the representations made, individual people coming up and pleading their case.” (LA1, LB Member)

These quotations suggest that opportunities for conversation or hearing individual representations can inform LB decisions. However, it was additionally apparent in the data that LB members drew upon their own individual backgrounds and experiences, or other sources of tacit knowledge, to help make sense of evidence. These individual characteristics appeared to help explain some of the diversity within LBs, with interviewees often being explicit about how their personal or professional experiences could shape their overall perceptions of evidence and their subsequent decision-making:

“We might have experience in previous lives before we were Councillors... I have worked with people who have been victims of

domestic abuse and that is often come about as direct effects of their partner drinking. I've seen the affect that alcohol can have on individuals. I can see walking around the place the effect sometimes that alcohol will have.” (LA1, LB Member)

“It is building that knowledge of our own personal knowledge and experiences, a knowledge of our wards and the effects it has there. The knowledge of where we live, if they are different and someone and their knowledge of what it is like and knowing what it's like not just for people who use the premises but people who live by them. Yes, we bring in our own experiences but of course that doesn't mean to say we all agree.” (LA1, LB Member)

These quotations suggest that LB members were aware of how they brought elements of their own backgrounds with them into their licensing roles, and that this would help to shape their culture of evidence (similar to ADPs). Another important element of LB members' backgrounds and understandings they bring with them was illustrated in the following quotation:

“we haven't...refused a license on the grounds of the impact on people's health...I think it's because a number of Licensing Board members either don't, they don't read the information they've got or don't accept there is a real problem with alcohol in Scotland and in [LA1]. So that reason's never, I don't think, taken as seriously as a reason why you should refuse someone to have a license. (LA1, LB Member)

This quotation suggests that LB members' interpretations of evidence are being shaped by their broader perceptions of alcohol use and harm in Scotland. Further, it speaks to the potential impact that local actors' perceptions of evidence can have implementing Scotland's alcohol strategy.

In addition to their own experiences, their colleagues and members of the public, LB members reported receiving evidence from formal sources which exist to support the licensing system, such as Licensing Clerks and Licensing Forums. The roles of these actors were notable in the data, particularly in the case of Clerks, who are described as having a key role in the evidence funnelling, collating, and even filtering process described above in relation to the licensing documentation package:

“My own view is that they're very much guided in their decision-making by the Licensing Board Clerk who is a qualified solicitor. Who, if you like, filters their own thoughts and values and ensures that it keeps in step with the policy that they've agreed.” (LA3, licensing stakeholder)

“You get all the statistics for the areas... (AW: Who provides those statistics to you?) ...The Clerk of the Board, who’s a lawyer. You get information given to you.” (LA2, LB Member)

“Well the Clerk gives us all the relevant policy details usually, so we know what were’ looking at” (LA1, LB Member)

These data suggest that Clerks are perceived as a trusted and credible source of information, partly because they have technical expertise which enables them to identify what is relevant to LB members. This is aligned with Fitzgerald and colleagues’ (2017) observation that Clerks hold power rooted in their legal expertise, but builds upon this to note Clerks also perform this ‘funnelling’ function in relation to LB evidence.

Licensing Forums (discussed in Chapters 2 and 6) appear to be perceived as a credible source of evidence when they are representing (or at least communicating) what the ‘community’ opinion is on a given issue. A specific example of this was reported with regards to weekend license times:

“We recently changed the licensing on a Sunday...the Licensing Forum were quite good at giving us kind of feedback about what, what communities thought about that. ‘Cause for years we thought that’d be hugely contentious issue, but the Licensing Forum were able to say, as representatives, community groups across the city, people are not concerned about it.” (LA1, LB Member)

Another LB member articulated why they perceived meeting with the Licensing Forum as valuable:

“So they [Licensing Forum] then bring out certain things that they would like to go or what we think about that or how they think it’s been run... So that way keeps us in contact with, that loop with everybody, if you see what I mean, from a cross section of people. From the pubs who are selling it right down to the ones who are getting the sharp end, likes of Alcohol Focus or, you know, some of these groups.” (LA3, LB Member)

This quotation suggests that, while meeting with the Licensing Forum is mandatory for the LB, this information is perceived as valuable because the Forum seemingly represents (and can therefore connect LB members with) public opinion. This perception appeared to be shared by LB members across the local areas, although one member from LA1 expressed hesitation given the Forum included members from the licensed trade. Further, these quotations suggest a more meaningful role

for the Forum than other data in this research. For example, this is somewhat in contrast with the way LB members were quite dismissive of their relationship with the Forum or any feeling of accountability to them, as briefly discussed in Chapter 6.

In addition to the sources discussed above, LB members also discussed receiving evidence from the statutory organisations who are permitted to participate in licensing meetings, particularly police and health representatives (who were not necessarily members of the ADP⁵⁸). The data suggested that LB members had different perspectives about the value or credibility of evidence from these organisations. In general, police sources of data appeared to be trusted and valued. For example:

“At the point of making the decision for me fairly often the most persuasive people are the police...They tend to have a very pragmatic- our officers have a very pragmatic approach. They don't tend to dress things up or over sensationalise something....I find they balance information they give us...And they will- primarily with the police they will be taking about on-sales in the pubs and the clubs of an area so they are providing us with the statistics to do with that, that area and we know that the...change to a licence or a new licence will have a direct impact on where they are talking about.” (LA1, LB Member)

“But pretty much you base it on a report that's put in front of you from Police Scotland. They're the biggest sway before us I suppose because it's quite often about crime or preventing crime and disorder, and you don't want to be responsible for creating more crime and disorder. So they're the biggest providers of information” (LA1, LB Member)

In contrast, health sources were more often critiqued, a result which appeared to be related to how health stakeholders linked public health evidence with licensing decisions:

“I suppose what my problem with the NHS is, (pause), I'm not convinced that all of their arguments are relating to the problems as we actually see them. I think they come from, 'yes we've got a problem, we have to deal with the carnage' they would put out the problem drinkers [...] I'm not convinced that there's a direct linkage about decision the Board's making and relation to what they're actually seeing. Because that, what I say, I can't get that argument because the number of outlets distantly affects the outcomes at the NHS. They'll give us ideas where they're saying there's huge

⁵⁸ For example, in LA1, the member of Police Scotland who attended the LB was not also member of the ADP, however their police colleague was (with whom s/he worked closely).

area of alcoholism in that area. Those areas have hardly any bars in them at all. ” (LA1, LB Member)

However, it was evident that this approach remained challenging, for example due to a lack of available high-quality evidence. For example, an NHS representative among the ADP interviewees pointed out:

“The licensing data is very poor. They don’t collect it very well; they don’t collect it for statistical purposes really. Hopefully that will improve...because I kind of argue back to the Council saying, ‘well, if you want evidence-based policy, if you’re saying I haven’t presented enough evidence to you, one of the things that’s holding me back is the fact that the Board can’t give me the data that we need to help you develop the evidence.’” (LA1, ADP Member)

I explore LB members’ perceptions of health evidence further in the following subsection which explores the importance of how evidence was presented. For now, the data suggest the police are, for the most part, seen as a credible source of information which can be directly relevant for licensing decisions. This may have been grounded in a specific experience of some LB members in LA1 - they listened to a police briefing and participated in a Saturday night patrol, which seemed to provide further experiential and contextual information about the local impacts of alcohol. The participating LB members provided vivid descriptions of what they observed, with the above member stating the experience “illustrates the sort of things that...the police and the ambulance services have to put up with” (LA1, LB Member). It seems that police representatives to the LB have effectively linked issues of crime and disorder to alcohol use, by using different types of evidence (e.g. reports or experiences for LB members).

There was one reported exception among the LB members’ generally positive perceptions of police evidence - an LA1 LB member reported s/he thought the police sometimes exaggerated their reports in order to manage the night-time economy. Mostly, however, it appeared s/he was critical of the police reports when they did not align with her/his own, self-identified ‘liberal’ attitudes. Indeed, elsewhere in their interview this LB member named the police as one of their primary sources of information when making decisions.

The preceding section on ADPs found they are continuously thinking about how to persuade others outside the ADP, including LBs. LB members consistently reported

that the ADP had an opportunity to feed evidence into the LB's process of developing their Licensing Policy Statement once every 4-5 years (during consultation), but beyond this particular 'window of opportunity' (Petticrew et al., 2004) they had limited interaction with the ADP as a whole:

"I separately meet with [LA1 ADP Coordinator] a number of times to talk about when we were forming the last Licensing Policy, about how we might be able to get it tweaked to help what [s/he] would like around NHS, so I have, personally I have a good relationship with the ADP, well, with [LA1 ADP Coordinator]. But the only real involvement that we have with them is through when we set our Licensing Policy which is every couple of years or so... So they're active at that point of informing, or trying to shape each policy as we set it, then after that they don't have any involvement in the Licensing Board." (LA1, LB Member)

This suggests the ADP as a partnership is very restricted in its opportunities to inform LB decision-making. This is different from individual statutory organisations such as health or police, who are members of the ADP but feed into the LB on a more regular basis as statutory 'consultees'. This is potentially important for alcohol policy implementation, because national expectations are that ADPs will be involved in licensing (see Chapter 5), however there appear to be limited opportunities to do so. Further, the previous section showed ADPs perceive limited success in persuading LB members with evidence even when they do manage to engage.

The above data have suggested that the licensing process provides opportunities for LB members to source evidence from different individuals or organisations. However, among these results it was clear that, within a given LB, individual members had different perceptions of these sources of evidence. This was summed up by one LB member:

"If we have come to a different opinion it's because we've listened to various experts and various people contributing to it and feel that they have some merit and perhaps our colleagues disagree" (LA1, LB Member)

It is apparent that differences partly reflect LB members' perceptions of the credibility or trustworthiness of certain sources. This will continue to be evident in the subsection below in which public health sources of evidence are discussed, highlighting the significance of how public health evidence was *presented* to LBs.

Presentation of Evidence

Akin to ADPs, a key element of LBs' culture of evidence (as identified in the interview data) was the presentation of evidence and its impact on evidence assessment and use. This was most apparent in data regarding LB members' reported perceptions of NHS or public health evidence, which appeared to contrast with perceptions of police evidence (as discussed above). In particular, while health stakeholders were considered to be a potentially important source of evidence, the manner in which health evidence was presented reportedly frustrated LB members:

"At every meeting the police, the building control, the licensing guys, and the health, are expected to be there because they can raise their objections. Unfortunately, the health guy just reads everything that he's written, and that's it they're thinking 'I've read this, I don't need to see it again' and that frustrates me. A trivial point but it just annoys me...'Cause it's that opportunity to say 'yep you put in the official document, now tell your story, tell your story about how that is going to damage people in your community.' That's his opportunity, but... (shrugs)." (LA1, LB Member)

The licensing culture of evidence tended to privilege or value characteristics of evidence which were not always present in public health research, for example a need for local specificity of evidence (as opposed to de-contextualised, population-level public health evidence). This was recognised as a challenge among national level interviewees, one of whom described public health and local authorities as communities that "basically spoke different languages" (National Level 9).

Furthermore, LB interviewees had mixed perspectives on the role of the NHS representatives in providing that evidence. A spectrum of views was identified in the data: three licensing interviewees appeared most welcoming to evidence provided by the NHS (and persuaded by health and 'alcohol availability'-related arguments), three were much more dismissive of NHS evidence they had seen, and the rest were more equivocal. Those that were dismissive varied in their reasons for this, including, as illustrated in the quotes below, scepticism towards the availability argument (as opposed to 'personal responsibility') or insufficient communication of evidence on overprovision:

"I'm not clear in my own mind about the true definition of overprovision. If you're saying by having too many bars it'll cause problem drinking, how many do we have to reduce to before problem drinking goes away? If there are two off-licenses in a street, and somebody with a drink problem wants to get alcohol,

they've got a choice of two. If there's a choice of one, they'll still get alcohol. But if they have a choice of five, they're still going to get the same choice." (LA1, LB Member)

"The NHS...come up with absolutely ridiculous stuff. You look at it and you think, these people are not in the real world, you know. There is no way we could do that...You talk about overprovision...every licence that we get in for a licensed premises, they've got an overprovision [objection] in. And we've already had a word with them saying, don't send this...you must have just your machine in there and it just clicks about, you change the name and bang it out. That's useless...What I would say is, to stop listening to the NHS too much unless they start really getting detailed analysis and not general broad brush" (LA3, LB Member)

The first quotation suggests a resistance to population-level evidence supporting the link between alcohol availability and (risk of) harm – a tension that has been previously discussed as a challenge in Scotland (Fitzgerald et al., 2017). However, the latter quotation also suggests a frustration when public health actors are seen to repeatedly apply the same objection statement to applications. When asked what they would prefer to receive in terms of evidence, this interviewee stated they wanted "More context. More, deeper analysis. More detail." (LA3, LB Member). By being presented in a generic, or decontextualised manner, public health research as a source of evidence ends up being perceived as less credible than other sources (i.e. from the police, discussed above) which are viewed as more detailed or relevant to the specific, local, individual licence decisions. A reflection from an LA1 health representative is worth noting here, which expresses a sense that the evidence in and of itself is unlikely to be persuasive to their LB audience, and thus developing relationships was the approach they were currently taking:

"it's so well documented the evidence on its own which just gets you nowhere. So, I think, I've always also had my mind thinking how do I build a credible relationship with [LB members] without becoming, without getting dismissed by all of them, just as the health lobby who's just whining on about alcohol... sometimes I think actually with some of these folk, I am not going to persuade them." (LA1, ADP Member)

This relationship-building effort may have been somewhat productive, as another LB member from LA1 shared a similar critique regarding how evidence is presented by the Health Board, but expressed greater empathy towards the health representative:

“You’ll base your decision on that case on what’s in front of you. And if the letter from the Health Board – quite often is – the exact same one as you’ve just read and the one before that, you just start ignoring them. And I’ve talked to the health [representative] ‘cause I like [them]... ‘I think you need to stop just giving us facts and figures about the policies...you change your tack and it might impact more, people will listen to you because they just switch off. Because you’re just running on about health policy and alcohol policy and Scottish Government policy. And it’s fairly irrelevant to [how] a local ward is perceived, it’s fairly irrelevant to a local licensing application. If you were to tell a different story about it, about how many people in that street or that community had suffered an alcohol illness or death, it might make a bit of difference.” (LA1, LB Member)

This quotation again demonstrates the importance of the evidence provided to LB members on their meeting day, and the need for it to be presented in a way that is considered useful and contextualised. This suggests that even if the content of evidence is potentially robust, and the source of the evidence is credible, it remains important to present it in a way which emphasises its relevance to the local context for which licensing decisions are being made. This quotation also adds nuance to the understanding about how persuasive statistics can be – that while numbers may be important (as discussed above), local stories may connect more meaningfully with some licensing decision-makers. This again supports the idea that quantitative data is most persuasive when it helps illustrate or substantiate a narrative about the local context. It also helps to show some of the complexity in how licensing decision-makers are perceiving and using evidence.

An example of this complexity repeatedly arose in interviews on the topic of overprovision. The level of detail and contextuality in the presentation of evidence that LB members sought from public health often appeared to be linked to how nuanced their assessments were of individual licenses and overprovision. Most licensing interviewees expressed (unprompted) perceptions that different types of licenses could result in different benefits or harms to their community, and this influenced how they perceived the applicability of public health evidence. This was most commonly illustrated in their perception that off-licences were more problematic (in terms of encouraging cheap drinking at home) than restaurants, pubs, or hotels (which were seen to contribute to ‘village life’, tourism, and/or job creation).

“I’ve always found it really difficult to treat all alcohol licenses in the same way [...] The areas of overprovision I find problematic because you are brandishing all these, the pubs, the restaurants, the clubs, specialist shops, supermarkets, corner shops, in all the same way and they don’t work in the same way. They don’t sell to the same people. They don’t sell in the same quantities.” (LA1, LB Member)

Another LB member from LA1 stated that “we do implement the [overprovision] policy, but the policy is open to interpretation”. S/he went on to discuss this interpretation, using the example of being willing to give a new hotel an alcohol licence even if it applied in an area of overprovision:

“because it’s in an area of overprovision there will be objections because by the very nature we’ve designated that, NHS Scotland will probably come forward and say there’s too many bars in that area, the police would probably do it, and perhaps even the Licensing Officers. And all they would be doing would be reflecting the Board’s own policy on overprovision. But I suspect the Board make take a benevolent look at that type of application.” (LA1, LB Member)

The quotations above speak to the “blunt instrument” (LA1, LB Member) nature of overprovision as a policy tool. While public health evidence or legislation may portray types of alcohol licenses as falling into categories (i.e. either as an ‘on-’ or ‘off-license’), LB members may value evidence which helps them assess licences and interpret ‘overprovision’ in more nuanced ways. Further, given the critiques interpreted in the data, it appeared there was room for improvement in how certain public health actors understand the needs of, or present evidence to, licensing actors.

This section has discussed the way LB members report perceiving the content/type, source, and presentation of evidence with which they engage during alcohol licensing decision-making. Comments from a Board member in LA1 neatly illustrates the interaction between these factors:

“Previously I’ve done night-time visits with the police where we went to nightclubs at one in the morning and seen them, and in fact the one I went to a fight broke out right in front of the police and we were able to stop it, I’m sure they set it up (laughing). But these visits have started happening, there’s just recently had a couple of Board members went but again, they’re the more sympathetic Board members that are prepared to say ‘yeah I want to go see what’s happening there because I think that, that helps your head when you’re making a decision about this is another

application'...But for a majority of Board members they've never experienced that and I think that again it's why I get back to the real evidence from [ADP] or NHS, people need to see or at very least hear this is what's happening. If you're not seeing it...all you're then getting in front of you is an objection from the police maybe, some technical things from other officers, but then a lawyer given the opportunity to argue his case in front of you, they're usually quite good. So your information sources are a written document from officers, a well-oiled licensing solicitor" (LA1, LB Member)

This quotation depicts different types, sources, and presentations of evidence available to LB members (e.g. experiential-type evidence sourced from police night-time visits) and how they describe acting upon them (an optional decision, if they wish to take advantage of these opportunities). It also demonstrates recognition among the members that they are engaging with evidence differently.

It is clear from LB member interviews that they consider evidence in terms of how persuaded by it, or how highly they value it, and that they often valued a mixture of numerical and more qualitative content. LB member interview data suggested LB members found evidence persuasive when it was sufficiently detailed, contextualised to the locality, and supported by the existence of personal relationships (and, ideally, aligned with members' pre-existing ideas about alcohol-related harm). Additionally, the data indicated a potentially important role for quantitative evidence when such data could be used to help tell a 'story'. These findings suggest the demands of Scottish alcohol policy implementers are consistent with alcohol policy implementation literature from other UK contexts reviewed in Chapter 3 (Foster, 2016; Haggard et al., 2010). The data also suggest, however, that public health evidence is not typically being delivered in this way, by contrast with legal or 'crime and disorder' evidence, which interviewees suggested was delivered persuasively more often.

Based on the data regarding types, sources, and presentation of evidence above, this section suggests there is a broad culture of evidence surrounding LBs. First, their culture of evidence appears characterised by a legal and political decision-making context; a need for evidence which is attained from a source they trusted or perceived as credible; and a need for detailed, localised/contextualised evidence that is supported by quantitative evidence. Second, that, like ADPs, their culture of evidence is informed by the diversity of their members. The data above suggest that

an important component of this culture of evidence is their explicit bringing (and valuing) their individual personal and professional backgrounds (and experiential knowledges) to their interpretations of evidence. Given that LB members are drawn from a range of backgrounds however (e.g. different professions, communities, and political leanings) prior to becoming local Councillors, the way these backgrounds influence their evidence use is also different (including as to whether and how they accept evidence about alcohol problems in Scotland).

7.3 Discussion

7.3.1 Principal Findings and Contributions to Literature

This chapter took forward a suggestion from Fitzgerald and colleagues (2017) which identified potential different ‘cultures of evidence’ among local alcohol policy stakeholders. I engaged with Lorenc et al.’s (2014) conception of such cultures to empirically investigate whether and how ADP and LB members perceive and use evidence in their work and their interactions with each other. The focus on ‘cultures of evidence’ enabled an exploration of the organisational-level evidence preferences of ADPs and LBs and thus offered new insights into the influence of organisational context (within their organisations and in terms of their external environments) on perceptions and uses of evidence. It further allowed for comparison and critical analysis about how the cultures may interact during alcohol policy implementation.

With respect to the research question this chapter addresses, the principal findings indicate that evidence indeed plays a central role in the context of local actors’ work to implement Scotland’s alcohol strategy. The findings suggest evidence helps shape decision-making by both ADP and LB stakeholders; that ADPs and LBs each have an identifiable culture of evidence which influences how they perceive and use evidence; and that these cultures can usefully be explored through their perceptions of types, sources, and presentation of evidence.

ADP and LB cultures of evidence share some core features. Both had a broadly identifiable organisational-level culture of evidence, a component of which was the diversity of perspectives contained within it. For both, this appears to be partly a result of the diversity of backgrounds, professional training, values, or other perspectives of the individuals who are brought together within ADPs and LBs.

Despite this diversity, however, the cultures of evidence of ADPs and LBs could be understood through analysing their preferences regarding types, sources, and presentation of evidence. For example, both reported using multiple sources of evidence, and requiring locally contextualised evidence. This similarity was unsurprising given what is known about how policy actors report desiring relevant, local, and actionable evidence (Kneale et al., 2017; McGill et al., 2015). However, and importantly for my research, interviewees suggested that this was not yet being sufficiently acknowledged in the provision of public health evidence to these organisations. The perceived lack of contextualisation of public health research may contribute to explaining the frustration that certain ADP *and* LB members expressed with this source of evidence. Interviewees from both expressed a sense of what they would like to know about alcohol problems or policy locally, but that the evidence provided to them from public health research often does not adequately address these needs.

Key differences between the ADP and LB cultures of evidence were observed. The overarching point is that evidence use among ADP and LB members appeared related to their organisational structures and contexts. For example, LB members appear to be using evidence within a legal and political context, while ADP members' engagement with evidence appears to be influenced by their policy context which is more administrative, partnership-oriented, and resource-constrained. Consequently, they tend to use different forms of contextually-determined evidence. Second, ADP members reported evaluating evidence based on whether it is useful to them *and* whether it useful when they try to persuade others. Some ADP interviewees appeared to make a distinction between evidence which was useful for them personally and that which was useful for persuading others (either in hopes of influencing others taking a particular decision, or to justify to others why the ADP itself made a particular decision). In contrast, LB members reported evaluating evidence only in terms of its usefulness to their own, individual, licensing decision-making. This suggests LB members position themselves primarily as recipients and users of evidence, and that evidence was always assessed in the context of broader policy narratives and with regards to its persuasive power.

Further, the system of licensing has inbuilt mechanisms to 'funnel' evidence for them in the form of the licensing documentation, which means LB members are typically

considering evidence which has been provided to them within particular formats (i.e. licensing documentation). While they have other opportunities to attain evidence beyond this (e.g. through engaging more experientially with police or health representatives), they are not expected or required to do so.

In contrast, the chapter demonstrated that ADPs were expected to engage with evidence as a core component of their alcohol policy implementation practice. Given this, ADP interviewees described complex relationships with evidence which involved developing, translating, and using evidence. They also described using evidence within their partnerships and 'knitting together' evidence to inform decision-making.

Having demonstrated that ADPs and LBs have cultures of evidence, an important question is whether this may to some extent explain the perceived failure/challenge of ADPs to influence and persuade LBs. This would in turn be a potential explanation for challenges to Scottish alcohol policy implementation. While they have similarities of both using multiple sources of, and valuing locally relevant evidence, there are clear differences in their context(s), what they deem to be useful, and how they use evidence. Indeed, even the similarities, namely using multiple sources, do not mean they use the same multiple sources at all times. As a result, this can help explain why the evidence that ADPs present/provide is not always as persuasive to LBs as desired, in turn being a challenge to implementation. Overall, my findings are largely aligned with Nicholls' (2015), who in considering evidence use in Scottish and English alcohol licensing from a historical perspective, suggested tensions between them in terms of what counts as evidence must be addressed if public health is to influence licensing. My findings confirm that significant differences exist and that these may be having a meaningful impact on ADPs' ability to influence LBs and progress towards public health-related goals of alcohol policy implementation.

In the Scottish licensing context, these findings build upon Fitzgerald and colleague's (2017) study of public health actors' perceptions of evidence, in which they reported the perception that licensing officials did not always understand or value health or statistical evidence. My findings suggest that some of these actors do respond to such evidence if it is perceived to be adequately contextualised and

helps to tell a story (e.g. by being combined with qualitative information). Further, my results speak in more detail to the perceptions of ADP members about what is most persuasive to other actors, including licensing actors.

While Fitzgerald and colleagues (2017) reported public health actors' perceptions that LB members may simply ignore public health evidence, my findings suggest the situation can be more complex. My data indicate that LB members draw upon many types of evidence, including public health evidence, but that public health evidence often does not fit well with the LB culture of evidence that values experiential accounts and stories. Therefore, public health actors should not assume LB members will prioritise, or be more persuaded by, public health evidence than these other types. Furthermore, Fitzgerald and colleagues reported LBs members may regard public health as beyond the legitimate scope of licensing. By contrast, the majority of my licensing interviewees did not express the view that public health was irrelevant to licensing, though they recounted both questioning this evidence and critiquing public health arguments. Reflecting the culture of evidence outlined above, these critiques often appeared based on their desire for evidence to be locally contextualised – in my data this emerged through a comparison between LB members' perceptions of health and police data, in which police data tended to be viewed as more useful because they appeared more locally relevant to particular licensing areas.

More broadly, the findings in this chapter are largely consistent with the results of the systematic review in Chapter 3. For example, a number of articles reported that a lack of evidence to inform their decision-making was problematic (e.g. Fitzgerald et al., 2015; Toner et al., 2014), and that certain implementing organisations respond by undertaking their own local context-specific research (Toner et al., 2014). My interviewees reported limitations with the evidence they had available to them, and described efforts to develop their own evidence to better address their needs.

Articles in Chapter 3 also reported that both scientific and non-scientific evidence is used within local alcohol policy implementation (Foster et al., 2007; Grace et al., 2016; Herring et al., 2008), in a manner consistent with understanding from evidence and policy literature. My results lend further support to this in the Scottish

context. For example, within their respective cultures of evidence, ADP and LB members appeared to sometimes combine or 'knit together' evidence to inform their policy work and decision-making. How they combined types of evidence differed, however. While ADP members reported ongoing interaction with a range of available evidence sources which they could use to piece together an informed sense of local needs, LB members reported using more clearly demarcated sources – for example evidence 'funnelled' into the licensing application documentation, and very contextual understandings of their local communities. These differences are important because implementation of Scottish alcohol policy may remain limited while key stakeholders are using, and finding value in, different types of evidence (i.e. if these different types suggest contradictory ways forward for tackling alcohol-related harm).

The reported requirement of both ADP and licensing actors to have detailed and locally contextualised evidence is also consistent with findings from Chapter 3 that local, contextually-specific data were likely to be most persuasive to other implementation stakeholders and perceived as most relevant by local officials (Foster, 2016; Haggard et al., 2010). This aligns further with broader public health literature. For example, Petticrew and colleagues (2004) have noted the need for evidence at 'micro level' is a key influence of evidence use in policy. Reported frustrations in my own data about a lack of locally contextualised evidence suggested, however, that local implementers currently have to work to translate evidence to their own contexts or allocate time and resources to generating their own evidence (e.g. in LA2). These frustrations perhaps help explain why interviewees suggested that evidence constructed in traditional public health settings (e.g. the NHS and universities) was not translating well to either setting, suggesting 'cultures of evidence' can conflict in ways that restrict the traction of seemingly relevant evidence.

Context and Resources

Existing literature examining the interactions between evidence and policy sees evidence use as inherently contextual (Contandriopoulos et al., 2010; Dobrow et al., 2006, 2004; Moat et al., 2013; Weyrauch et al., 2016). In this chapter, the concept of cultures of evidence was identified as being analytically useful for understanding evidence use in the context of alcohol policy implementation. My findings suggest

that the varying cultures of evidence among ADPs and LBs appear to be at least partially explained by their external and organisational contexts. For ADPs, their policy and partnership-working contexts complicated their relationships with evidence, while LBs' legal context and inbuilt autonomy helped explain their culture of evidence.

In this chapter, it has been observed that ADPs work in a policy and partnership context which influences how evidence is perceived and used. While the data in this chapter was able to identify an organisational-level culture of evidence for ADPs, at an individual level interviewees expressed varied perspectives on what they found most useful. These variations may have implications for how issues are problematized within ADPs and what solutions are pursued. This has the potential to both facilitate and challenge alcohol policy implementation. For example, multi-sectoral partnerships may be productive for alcohol policy implementation practice, such as when ADP members strategically combine evidence from different areas of expertise, to develop well-evidenced, joined-up arguments for other policy audiences. However, if partnership members' understandings of evidence and evidence needs differ in ways that appear contradictory (e.g. as a result of their different professional backgrounds or organisational perspectives), there may be potential for conflict. For example, in one ADP there was a clash between health and police representatives, because they examined problems and relevant evidence through different population and individual perspectives, respectively. Potential issues surrounding evidence use in partnership are important to address because partnerships continue to proliferate across local areas in Scotland, and this type of collaborative working continues to be perceived as the best way forward for public policy more broadly in Scotland (Scottish Government, 2017i).

Further to their partnership working context, ADPs reported perceptions and uses of evidence shaped by their role as local implementing officials who used evidence for multiple purposes. While ADP members assessed the value of evidence based on how useful or relevant it was to their own decision-making (i.e. whether they perceived it as reflecting, or sensitive to, local realities), they also spoke in detail about how they valued evidence when they thought it could be useful in persuading others. This seemed to be a result of their position in a complex local governance context, in which they needed to justify decisions to others in local government, as

well as try to influence stakeholders such as LB members. These findings suggest that the way ADP members use evidence in their work to progress the alcohol strategy's implementation is influenced by how credible they think others will find it. This introduces a performative aspect to their evidence use which seems to respond to their local governance contexts, in particular linking back to their accountability obligations. An implication of this is that ADP members appear to be playing a more substantive knowledge brokering or translation role than has been previously acknowledged in the literature. Further, they may require more support to do this effectively, particularly in circumstances such as licensing where ADP members are trying to have influence, but political and economic factors challenge this. Learning which may be useful to inform these efforts could be drawn from knowledge brokering literature, especially that which recognises the challenges faced by local policy practitioners (Kislov et al., 2017; Ward, 2017; Ward et al., 2009).

ADPs further reported that their relationships with evidence were influenced by the resource constraints they worked within. This is consistent with how Dobrow and colleagues (2006) conceptualise resource constraints as being a part of policy actors' "external decision-making context", which "modifies, facilitates and constrains" (p. 1817) their evidence use. Importantly, ADP members expressed a particular need to use available evidence to inform strategic decisions in light of recent budget cuts. ADP members also expressed frustration that insufficient resources constrained their capacity to act upon evidence (e.g. relating to the need for shifts to preventative approaches). Vice versa, ADP members also expressed irritation with evidence which recommended actions that were financially impossible. These findings suggest that ADPs may often, in effect, be prevented from undertaking evidence informed alcohol policy implementation work, despite expectations that they do so.

Turning to LBs, the findings suggest LBs continue to be preoccupied by their concern with the local economic and political contexts, which in turn shaped their own culture of evidence. For example, LB members appear to use their autonomy to interpret evidence in light of their perceptions of 'need' for tourism or jobs. Further, LB members' relationship with evidence appeared influenced by the structure of the licensing system and their role within it. Specifically, LB members work within a quasi-judicial, legal-type system in which evidence is often 'funnelled' to them in

particular formats, and needs to be demonstrably relevant to their specific decisions to be considered valuable. The findings suggested a consequence of this was LB members often did not consider public health evidence to be particularly relevant in this context (although they did appear to view local criminal justice evidence as relevant). This then presents a challenge to using the public health objective within licensing to help achieve the public health goals of Scotland's alcohol strategy.

Finally, in relation to interactions between LBs and ADPs, my data suggested the ADP as a whole appeared to have limited formal opportunities in which to interact with LB members to communicate or share learning. However, in terms of the organisational *members* of the ADP, LB members spoke more readily about having contact with the health or police representatives who attended LB meetings (discussed above). This suggests that other members of the ADP, such as social work or third sector representatives, are not able to access the LB through their membership of the ADP. It appears the licensing system still engages with ADP members as individual organisations (i.e. statutory or non-statutory), and not as a partnership. This has consequences for ADP members (beyond health and police) to be able to inform the licensing process, and for the ADP to potentially develop a unified voice with which to engage in licensing.

7.3.2 Consequences for Scottish Alcohol Policy Implementation and a Potential Opportunity

This chapter has made a contribution to understanding the role of evidence in the context of Scottish alcohol policy implementation. I reflect here that the findings may also have more distinct consequences for the implementation of the alcohol strategy. First, it was reported that public health evidence often does not strongly influence LBs. A consequence of this is they continue to make licensing decisions which impede progress on addressing availability of alcohol, thus limiting progress overall towards the goals of the alcohol strategy. Generated from interviews with LB members, this finding confirms results gleaned from public health actors' perspectives in existing literature (e.g. Fitzgerald et al., 2017).

Second, ADP members reported often lacking the evidence they required, either in terms of evidence being contextually-specific enough or targeted to their research needs. This has potential consequences for how well they are able to inform

decisions, and then justify them, when implementing the strategy. This challenge is important particularly when decisions are increasingly pressured in light of reduced budgets, where value for money becomes even more important to demonstrate, and given explicit guidance from Scottish Government that their decisions need to be evidence-based (COSLA et al., 2015; Scottish Government, 2009c). While certain ADP interviewees reported filling this evidence gap by accessing context-specific, experiential-type evidence, this was often reported as not being a type they could use to justify decisions. This tension – between evidence they have available but cannot always use, and evidence they lack but are expected to use – increases the complexity of the implementation role ADP members are navigating and may frustrate both the implementation progress and public health actors' efforts to influence this with available evidence.

While the Scottish alcohol strategy itself is 'evidence-informed', challenges remain in ensuring its' implementation can also be so. In terms of addressing this, evidence use only seems likely to substantially increase if: (i) there is a greater organisational focus on supporting evidence use within ADPs, including efforts to better embed mechanisms designed to support evidence use (e.g. internal mechanisms such as needs assessments, or external mechanisms such as greater resources); and (ii) efforts are made to ensure available evidence better meets local implementation needs. Regarding the latter, one approach to achieving this may be via collaborating with academic partners (e.g. see Cherney et al., 2015; Holmes et al., 2017; Hunter, 2009; Nutley, 2003).

As discussed, one of the 'audiences' ADPs try to persuade are LBs. A potential opportunity for addressing the 'epistemological discord' between ADP and LB approaches to evidence may be emerging. In 2019 the Scottish Government held a consultation on draft Revised Guidance for Licensing Boards, which seeks to update the 2007 Guidance and provide greater clarity for LBs (Scottish Government, 2019b). The draft revised guidance⁵⁹ has been developed by the Government and working group that includes the Council of the Scottish Institute of Licensing, AFS, and health professionals (Scottish Government, 2019b). Of particular interest within the draft revised guidance are the details provided about how LBs can assess

⁵⁹ The final version of this guidance is not yet available at time of writing.

overprovision, and the factors (i.e. evidence and data) they may take into account during this assessment. However, the guidance states the overprovision assessment “must be based on credible evidence of a causal link...between the engagement of one or more of the licensing objectives and a concentration of licensed premises...in a locality” (Scottish Government, 2019b, p. 27) and that, “It is for the Licensing Board to determine...how the evidence will be interpreted and weighted” (p. 22). While the definition of a ‘causal link’ refers to ‘locality’ level in the area (as opposed to individual premises level), it seems likely that the tension between available measures of population-level harm and the need to demonstrate localised levels of harm will persist.

7.4 Conclusion

This chapter aimed to explore whether and how evidence informs local decisions about implementing Scotland’s 2009 alcohol strategy, and to explicitly build upon existing alcohol policy implementation research (Fitzgerald et al., 2017). It found that evidence did indeed inform local decisions about alcohol policy implementation among both ADP and LB members, and that their perspectives on, and uses of evidence permitted the identification of distinct ‘cultures of evidence’ at organisational level. Similarities between these cultures of evidence included that: they valued locally contextualised evidence; quantitative evidence was perceived as more useful if combined with local stories; neither perceived public health or academic evidence as being particularly persuasive because it tended to be decontextualized; and, importantly, the cultures of evidence for both ADPs and LBs were observed to be additionally complex because of the diversity *within* each organisation. Despite these similarities, however, interaction between the two in terms of evidence use remained challenging. This could be at least in part explained by the differences in their cultures of evidence, including the different legal and policy contexts in which they worked, the greater importance LBs placed on how evidence was presented, ADPs’ use of evidence within their partnerships, and that ADPs both used and translated evidence to persuade others while LB members tended to position themselves solely as users of evidence. It was also found that the LB does not often interact with the ADP as a partnership, because the licensing system primarily provides opportunities for only some statutory organisations to engage with LBs.

8 Discussion

8.1 Introduction

As outlined in Chapter 1, investigating implementation in the field of alcohol policy has been identified as important globally and specifically in Scotland (Alcohol Focus Scotland, 2019; Fitzgerald et al., 2017; MacGregor et al., 2013; WHO, 2019).

Further, Scotland has been heralded for its ambitious and innovative approach to tackling alcohol-related harm (Hilton et al., 2014; Trueland, 2016). The plaudits for Scottish policy notwithstanding, however, levels of alcohol-related harm remain high (Audit Scotland, 2019; Giles and Robinson, 2019). Policy energy and resources, and research priorities, have often remained focused on national-level initiatives, most notably MUP, while a relative dearth of research has been available to explain local processes of implementation. This research sought to investigate the gap between aspirations of Scotland's alcohol strategy and what happened locally, in practice.

Given that I discussed my empirical findings in detail in Chapters 5-7, this chapter explores what I consider to be the key findings of the thesis in relation to the research questions, and reflects on how these findings relate to existing literature. I will then explore my contributions through a discussion of governance challenges in multi-sectoral collaboration, namely partnership working, and policy coherence in the context of Scottish alcohol policy implementation. Finally, the chapter reflects on the overall strengths and limitations of the thesis, and identifies potential directions for future research.

8.2 Addressing the Research Questions

Chapter 3 presented a systematic review of the literature on alcohol policy implementation in high-income settings. This is, to the best of my knowledge, the first such systematic review of alcohol policy implementation literature. It found that resources, performance measurement, partnership working, evidence use, and public involvement have previously been identified as factors that help explain alcohol policy implementation variation, successes, and challenges in high income settings. Importantly, the review highlighted key research needs which could make contributions to knowledge in the field of alcohol policy implementation, and which my research was designed to address. The results chapters were organised to

address two research questions in order to achieve the overarching research aim of investigating what factors shaped the local level implementation of 2009 Scottish alcohol strategy. Further, the thesis considered how contextual factors and resources appeared to shape the local implementation of Scotland's 2009 alcohol strategy.

8.2.1 Research question 1: How was local implementation of Scotland's 2009 alcohol strategy influenced by formal and informal accountability mechanisms in the contexts of Alcohol and Drug Partnerships and Licensing Boards?

In Chapter 5, ADP members reported experiencing an accountability regime characterised by complexity, confusion and miscommunication. This included significant formal pressures from Scottish Government, challenges in intra-partnership accountability, and, to an extent, an informal sense of responsibility to service users. These different, but overlapping, accountabilities, and the confusion surrounding them, created challenges for ADPs' implementation work. Specifically, ADP members reported a lack of clarity about what was expected of them, weighty reporting obligations to Scottish Government, and difficulty in balancing formal top-down accountability obligations with their perceptions of service user needs. Further, ADPs' partnership structures presented challenges to implementation, possibly because of a lack of horizontal accountability across the partner organisations involved. ADP members' experiences of being held collectively accountable for implementation activities was perceived as confusing (and sometimes unfair), given the non-statutory nature of ADPs' structure.

The findings demonstrated substantive differences in the accountability regimes of ADPs and LBs. In contrast to ADPs, in Chapter 6 the findings showed that LBs' accountability regime almost exclusively relies on legal accountability arrangements, which do not sufficiently ensure that they contribute to the public health goals of Scotland's alcohol strategy. My findings demonstrated that this was, in large part, because LB members in practice have the freedom to prioritise (and indeed often do prioritise) economic considerations over public health ones, despite the formal imperative of the public health objective.

Together, Chapters 5 and 6 demonstrated how a research focus on accountability increases understanding of specific challenges of advancing implementation of a national strategy at local-level across diverse organisations. Some elements of my findings were broadly corroborative of, or aligned with, existing literature. These included, for example, that challenges arise when local implementers are forced to continuously fulfil multiple, simultaneously-experienced accountability obligations and when there is a lack of clarity over responsibility for meeting relevant health targets (Chalmers et al., 2016; Fitzgerald et al., 2015). Additionally, where Fitzgerald and colleagues (2017) reported perceptions among public health actors that LBs tended to prioritise economic considerations over public health, my data from LB interviewees themselves appears to confirm this.

In extending existing literature, my analysis was able to shed significant new light on the complexity of Scottish ADPs' accountability regimes and juxtapose these with LB accountability. In light of the findings from the systematic review, these findings regarding accountability are novel in respect of alcohol policy implementation in high-income countries. As has been previously noted, while issues related to accountability have been discussed in the literature previously, this is the first analysis of alcohol policy implementers' regimes in Scotland (and, to my knowledge, in high-income countries globally), which includes consideration of both formal and informal accountability as well as different 'directions' of accountability relationships.

8.2.2 Research Question 2: What roles (if any) did evidence play in the implementation of Scotland's 2009 alcohol strategy?

The second research question was addressed in Chapter 7, via an analysis of the role of evidence in alcohol policy implementation. The chapter presented the first substantive analysis using 'cultures of evidence' (Lorenc et al., 2014b) in two key organisational settings for alcohol policy implementation in Scotland (ADPs and LBs). This analysis expanded on the work of Fitzgerald and colleagues (2017), which had flagged the 'cultures of evidence' concept as potentially useful. It also built upon the findings of the systematic review in Chapter 3, which demonstrated that understanding evidence use within alcohol policy implementation work helps explain some of the challenges that implementers faced in their policy work.

The principal findings here are that: evidence does play an important role in the local implementation of Scotland's alcohol strategy since evidence helps to shape decision-making by both ADP and LB stakeholders; and ADPs and LBs each have an identifiable culture of evidence which influences how they perceive and use evidence. Their cultures of evidence can usefully be explored through their perceptions of types, sources, and presentation of evidence. Furthermore, there were discernible similarities and differences across ADPs' and LBs' cultures of evidence.

With respect to similarities, both were open to multiple sources of evidence but generally preferred locally contextualised evidence. Related to this preference, the findings indicated that evidence constructed in traditional public health settings (e.g. NHS and universities) was often perceived by local implementers not to translate well to local implementation settings (either in ADPs or LBs). This appeared to be a consequence of the perception that public health evidence tends not to provide solutions to the challenges implementers are facing locally, or to be cognisant of resource-constrained contexts. For example, interviewees said they felt that public health evidence was often not providing actionable recommendations for how to effectively address local needs (e.g. reducing service delivery in light of budget cuts).

In terms of differences, it was shown that ADPs and LBs were assessing and using evidence within different organisational contexts (i.e. a partnership-oriented policy context and a legal and political context, respectively). Further, that the organisations have different relationships with evidence – the findings suggest ADPs may develop, use, or translate evidence in their implementation work, and use evidence to persuade others, while LB interviewees positioned themselves exclusively as relatively autonomous users of evidence.

Having demonstrated that ADPs and LBs have identifiable cultures of evidence, I posited that this helps to explain the challenges ADPs report experiencing when trying to influence and persuade LBs and, in turn, broader challenges to Scottish alcohol policy implementation. For example, despite the similarities between their cultures of evidence – such as using multiple sources – the data suggest that ADP and LB members do not necessarily value or use the same sources. This may help

explain why the evidence that ADP members present to LBs is not always as persuasive to LBs as ADP members hope. Furthermore, this issue sits in the context of the governance of local alcohol policy implementation, in which ADPs as a whole partnership have limited opportunities to interact with the LB, and LBs act relatively autonomously to interpret evidence related to alcohol availability, overprovision, the economy, etc. Overall, the findings helped to illustrate that in Scotland's local alcohol policy arena there is not a unified public health approach to evidence, or even a single culture of evidence. Further, that there is not a simple health versus non-health gap or tension (as discussed in Lorenc et al.'s 2014 systematic review) which could be solved by simple mechanisms to 'bridge' or 'translate' health messages for non-health actors.

Together with the results from the systematic review, these findings for this research question may have implications for public health policy researchers. It is apparent that health actors who provide evidence in alcohol policy implementation spaces need to have a better awareness and understanding of different cultures of evidence and of related implications for local implementers' evidence needs and use. Additionally, my findings suggest that public health researchers should not assume evidence that is considered to be credible and valuable in their own contexts will necessarily translate well into those operating within other culture of evidence. At its starkest, my data suggest that the evidence public health researchers are currently producing is not considered useful or persuasive to local implementers. Public health evidence that foregrounds contextual and locally-specific issues, which combines quantitative evidence with meaningful narratives, and which is cognisant of resource-constraints may fare better. Future work could be usefully informed by contemporary evidence and policy literature which recognises the importance of institutional, political, and other contextual influences on organisational-level evidence use (Flitcroft et al., 2014; Hawkins and Parkhurst, 2016; Willis et al., 2017).

8.3 Role of context and resources in local implementation of Scotland's 2009 alcohol strategy

Resources and context have long been identified as critical considerations for effective policy implementation (Exworthy and Powell, 2004; Hill and Hupe, 2014; Howlett, 2018; O'Toole, 2004). Within each results chapter, I highlighted key findings regarding how context and resources were influencing alcohol policy

implementers' experiences of accountability (Chapters 5 and 6) and cultures of evidence (Chapter 7). Those sections helped this thesis make an empirical contribution to explaining how context and resources shape, challenge, or otherwise facilitate Scottish alcohol policy implementation in the three local areas included in this research.

With regards to ADPs (Chapter 5), my results suggest that the funding structures and governance approach to supporting ADPs are currently presenting a challenge to their partnership working and accountability, and thus their overall implementation work. The 'catastrophic' budget cuts faced by ADPs during this research were evidently strongly influencing their implementation decision-making. Given the severity of these cuts, ADP interviewees reported it was profoundly problematic that they were still expected to deliver on alcohol policy activities at pre-cut levels. Additionally, constrained budgets appeared to challenge ADPs' partnership working, by appearing to foster competition between partners, potentially damaging their ability to collaborate effectively. Further, variable engagement from partners and different understandings of the role of ADPs were evident, as were imbalances in authority between statutory and non-statutory organisations on ADPs, creating challenges for horizontal accountability.

Crucially, ADPs' status as a non-statutory partnership (without the ability to hold financial resources), and the structures within the ADP which did not appear to allow (or encourage), in a straightforward way, the pooling of resources among partners, contributed to these partnerships' financial challenges. Additionally, in terms of their collective uses of evidence, ADPs are not regularly treated as partnerships by their licensing colleagues, because only statutory organisations are able to regularly submit evidence to LBs. In particular, differences in financing among statutory and non-statutory members and the overall constraints on resources presented challenges for how the partnership worked (including who was held accountable for achieving policy goals, and how this occurred) and what it was able to accomplish in an already-financially constrained local policy context.

It is clear that concern with the local economic and financial context was a persistent influence on LB decision-making and their accountability regime (Chapter 6). This was evident in LB members' concern with the economy and, in relation to resources,

their fear of the financial (and potentially political) cost of appeals in court. The latter was particularly problematic, with appeals having been identified as the only formal accountability mechanism for LBs; such fear may lead LBs to grant licenses almost by default, significantly impairing the effectiveness of the public health objective. In terms of informal accountability, my data indicated a concern among LBs of not wanting to contradict or impede the actions of another committee, suggesting they were influenced to a certain extent by their local political context. In LA1, this was framed in terms of perceptions that the Planning Committee wanted to bring 'prosperity' (a positive framing) and the local LB not wanting to make a decision which would go against prosperity (see page 221).

The findings in Chapter 7 showed that the contexts of LBs and ADPs helped to characterise their different cultures of evidence. My analysis suggested ADPs work in a policy and partnership-working context which influenced how they assessed and used evidence as individuals or in combination with each other. ADPs' policy context also required them to use evidence to persuade others or justify their decision-making in the context of alcohol policy implementation (an issue linked to their accountability regime). This suggested that the way ADP members use evidence is influenced by how credible they think their audiences will find it, and identifies an important evidence 'translation' role for these local implementers. In contrast to ADPs, the findings in Chapter 7 suggested that LBs remain influenced by their concern with the local economic and political contexts, which in turn shaped their own culture of evidence. A potential consequence of this was that LB members often did not consider public health evidence to be particularly relevant to their licensing decisions (as noted in the analysis for Research Question 2). These findings suggest these elements of LBs' context presented consistent challenges to alcohol policy implementation across the themes of LB accountability and uses of evidence.

8.4 Governance Challenges of Multi-Sectoral Collaboration: Policy Coherence, and Partnership

The principal findings can be usefully explored with reference to key governance-related themes that cut across my findings from the systematic review (Chapter 2), accountability chapters (Chapters 5 and 6), and evidence chapter (Chapter 7). In

particular, the principal findings point to key challenges of multi-sectoral collaboration, specifically in relation to partnership working and policy coherence.

My analysis suggests that key challenges facing local alcohol policy implementers can be considered as intrinsic to multi-sector collaboration. Policy and legislative efforts to reduce alcohol-related harm are clearly not the sole responsibility of health actors – it is known that the contributions of other policy areas (e.g. criminal justice, economy, employment, education, etc.) are required to make effective change (World Health Organization, 2010). How these different sectors collaborate effectively is a central challenge to public health (Delobelle, 2019; Tangcharoensathien et al., 2017; WHO Europe, 2018), and remains a key issue in alcohol policy implementation (Institute of Alcohol Studies, 2019). While the data suggested that ADP members from diverse backgrounds generally agreed that alcohol-related harm needed to be reduced, they did tend to express different day-to-day key concerns or identify priorities in terms of alcohol policy implementation. This is aligned with broader literature which notes that weak collaboration and failure to find common ground among different stakeholders “remains one of the key reasons for subsequent implementation difficulties” (Hudson et al., 2019, p. 4).

Overall, while this thesis does not challenge the idea that multi-sectoral collaboration is a potentially positive, perhaps even necessary, approach for trying to address complex policy challenges, it does suggest that further work is required to enable such approaches to function well. While providing suggestions about what such work might involve is beyond the scope of this thesis, key challenges related to multi-sectoral collaboration were particularly acute and evident in my data. The following sections explore these challenges with specific reference to partnership working (as one particular, politically privileged form of multi-sectoral working) and policy coherence.

8.4.1 Partnership Working

Within UK public health policy there are longstanding assumptions that partnership working is a panacea to addressing complex challenges, however there is limited evidence of the effectiveness of partnership working for addressing these challenges (Dowling et al., 2004; Durand et al., 2015; Evans and Forbes, 2009;

Smith et al., 2009). These assumptions appear to exist in contemporary public health policy thinking (e.g. in Scotland's 'refreshed' alcohol and drug policy (Scottish Government, 2018b, 2018a)), despite a longstanding recognition of its potential pitfalls and how challenging partnership working is to do effectively (e.g. Audit Commission, 1998; Dowling et al., 2004; Markwell et al., 2003). In contemporary UK alcohol policy, these assumptions seem to have been embraced by alcohol policy stakeholders, with partnerships being the go-to structure for local alcohol policy governance (Foster et al., 2007; Lloyd et al., 2014; Martineau et al., 2014; Parkes et al., 2011; Thom et al., 2011).

Importantly, there has been an additional high-level assumption in policy practice that simply by mandating local actors work in partnership, effective multi-sectoral partnership working will naturally (even somewhat magically) follow (Evans and Forbes, 2009; Smith et al., 2009). Thus, thinking about both the process and outcomes of partnership working is often underpinned by ambitious, positive assumptions which lack substantive empirical support. While my findings do not seek to challenge the potential role of partnership in seeking to address complex policy challenges, they do suggest that effective governance structures to support this type of working may be lacking, and that there is a need for additional thinking and resources in order to function well. Within local alcohol policy implementation in Scotland, my findings suggest governance mechanisms have not been developed to allow or empower ADPs to truly work as partnerships, and this has impacted on their work to implement the 2009 alcohol strategy.

Specifically, the data in this research suggest there has been a failure to ensure that these partnerships are structured, resourced, and provided with guidance in such a way as to help institutionalise norms, practices and rules which would allow them to address fundamental partnership working challenges. Amongst ADPs, the data suggest that issues such as resources, accountabilities, and sharing/using evidence will be particularly important. These findings are consistent with alcohol policy research from the English context, in which issues such as limited funding and resources, managing size and complexity (with implications for accountability), and poor communication and information sharing have been identified as key barriers to effective partnership working (Thom et al., 2011).

My findings also suggested that ADP partnership working was complicated by ADPs' sometimes confusing accountability relationship with Scottish Government. As previously noted, the data suggested Government was perceived to be providing mixed messages about their role as a source of 'support' *and* as a top-down accountability forum. Further, frustration was expressed among ADP members about being held collectively accountable for implementation activities they did not have organisational or financial control over. This is aligned with observations from accountability scholars such as Thomas (2012) and Romzek (2011) who note that shifts to more collective approaches to accountability require mechanisms which can account for collaborative/partnership arrangements. It is also known from existing literature that striking a balance between central steering and local flexibility remains an important challenge for local partnership working (Markwell et al., 2003; Martin and Guarneros-Meza, 2013). In light of the above, my findings suggest further research into how Scottish alcohol policy implementation partnerships may be effectively structured and governed could make a meaningful contribution to knowledge to inform policy and practice.

8.4.2 Policy Coherence

My findings suggest that a contest of norms and goals is playing out in Scottish alcohol policy implementation at local level, particularly between public health and economic concerns. Key amongst this was the observation that, despite Scotland's national alcohol strategy explicitly prioritising public health concerns, economic considerations continue to be a dominant part of local decision-making (particularly in licensing contexts), and local implementers are struggling with this. This was most obvious with regards to the public health objective in licensing, where my data aligned with existing literature which notes some of the challenges Scottish policy actors have had in realising this objective (Fitzgerald et al., 2017; MacNaughton and Gillan, 2011; Nicholls, 2015).

In light of this, my research findings can be usefully examined through 'policy coherence'. This concept describes the extent to which conflicts between policy agendas (of different policy communities) are minimized, and synergies maximized (Blouin, 2007). In the context of policy implementation, inconsistencies across policy areas have been a target of blame for implementation gaps (Goggin et al., 1990),

while increased policy coherence provides a basis for better policy implementation (May et al., 2006). Three types of policy coherence, identified by Siitonen (2016) can be seen as useful here: horizontal (between policy areas, such as health and licensing); vertical (between policies of governments at different levels of governance, such as the Scottish Government and local Councils); and inter-organisational (between state and non-state actors).

In terms of horizontal coherence operating across policy spheres, this thesis has highlighted two sets of tensions. First, the section above (8.3.2) has outlined challenges ADP members face working horizontally together in partnerships. Second, the findings highlighted the tension between public health goals of the alcohol strategy (in this thesis, most often pursued by ADP members) and a consistent frustration of these goals arising from other actors' (certain LB members') concerns with economic aspects of policy. Achieving coherence would see these "different policy fields actively work together to achieve common overarching goals" (Stroß, 2017, p. 335). Instead, my findings suggest that while the national strategy's central goal is to reduce alcohol-related harm, and names reduced availability as a key contributor, LBs have the freedom to pursue different priorities from other local implementation actors. My analysis indicated this lack of horizontal coherence at local level was to some extent explained by LBs' lack of accountability (Chapter 6) and their 'culture of evidence', in which evidence was often considered against perceived local economic concerns. I reflect, however, that effective horizontal coherence may require public health actors to work to coordinate and integrate health concerns with other actors' social or economic goals, challenging potential assumptions among public health that health concerns should trump other types of concerns (Cejudo and Michel, 2017).

Second, examining vertical coherence between Scottish Government-level and local imperatives suggests there is still a need for mechanisms that can promote greater hierarchical synergy in Scottish alcohol policy implementation. This issue harks back to issues identified in early policy implementation scholarship, in which researchers stated 'hierarchical integration' was needed for effective implementation (e.g. Sabatier and Mazmanian, 1979). As discussed in the results chapters and above, there appears to be coherence between the Scottish Government and ADPs in terms of wanting to reduce alcohol-related harm. However, the ambiguity and

miscommunication between these actors (Chapter 5) led ADP members to report confusion and implementation challenges (so, shared goals but confusion about the governance processes to reach them). Then, while documentary analysis suggested the Scottish Government considers LBs to be important implementers of Scottish alcohol policy, Chapter 6 suggested LB members did not always agree about this aspect of their role, and the accountability regime of LBs did not ensure they contributed to the Government's public health goals for the strategy. The incongruence between Scottish Government and each of these local organisations has consequences for alcohol policy implementation, which can be usefully elucidated with reference to Matland (1995). Matland emphasises the importance of relationships across the policy implementation process, specifically noting that a given policy's level of ambiguity and conflict influence implementation decision-making. Together, the levels of ambiguity and conflict determine the character of a policy implementation process, with high levels of ambiguity and conflict directly challenging implementation. In my findings, this was evident in the complexity and confusion of ADPs' regime of multiple accountabilities, and the lack of accountability acting on LBs to ensure they contributed to the public health goals of the alcohol strategy.

Third, my analysis goes some way to suggest inter-organisational coherence is lacking between state and non-state actors in Scottish alcohol policy implementation. In Chapter 6, the findings showed that the accountability system for LBs unintentionally privileges the alcohol industry through concerns with how alcohol production and sales are related to jobs and local economies. This is despite the fact that employment is not a goal of the strategy (although there is acknowledgement of industry's role in the national economy) and that there is not an economy-related licensing objective. In comparison to industry, health actors' are necessarily disadvantaged in the licensing system (despite arguably having goals which are more coherent with the objectives of the alcohol strategy), because they do not have the same appeals' process available to them to challenge licensing decisions. This thesis' findings already help question whether having public health as a licensing objective has really been an innovative, progressive change for those seeking public health gains (Chapter 1). However, here I consider that, as long as there are insufficient governance instruments, guidance, or other mechanisms to ensure the prioritisation of public health over (or at least in combination with)

economic considerations, an unintended consequence is that local actors may default to the usual privileging of core local economic needs over public health. In light of this, it appears there has been an insufficiency of existing governance in order to flesh out what the public health objective means in that context, which sits alongside the de facto privileging of industry interests in other ways as well.

To help provide added analytical value of my research this section has discussed multi-sectoral collaboration, in particular in terms challenges generated from my data regarding partnership working and policy coherence. Ultimately, my findings are aligned with the observation that effectively overcoming challenges “may require new forms of alcohol policy governance architecture to ensure policy coherence and joined up actions between different sectors” (Anderson and Gual, 2011, p. 69). Indeed, this thesis provides more evidence that simply stating in policy documents that local policy work should prioritise public health, or establishing partnerships in hopes that such an approach will sufficiently address the complex policy tasks surrounding implementation, are neither currently working to ensure effective local implementation of the strategy’s public health priorities, nor likely to succeed in future. Rather, the findings suggest that different governance mechanisms are needed to allow the local system to better balance a concern with public health against or alongside economic consideration(s). What these forms of governance ‘architecture’ look like for Scottish alcohol policy implementation is an important topic for future research.

8.5 Revisiting the 2007 ‘Stocktake’

As discussed in Chapter 2, a 2007 Stocktake of Alcohol and Drug Action Teams (Cameron, 2007) provided a series of recommendations which the Scottish Government took forward in local reforms in 2008/2009. A decade later, my research provides the opportunity to revisit their recommendations in the context of ADPs, which replaced ADATs in 2009. Certain recommendations appear to have been embedded within ADP structures and operations, for example ADPs now develop Annual Delivery Plans, there is a range of representation on the partnership, and a Chair is chosen by the members. However, my findings suggest certain critiques of ADATs persist for ADPs, suggesting that Stocktake recommendations have not always been fully addressed.

Key among these critiques was that “for [ADPs] to be more effective, there must be greater clarity about what is expected of them and by whom” (Cameron, 2007). The authors additionally reported concerns among ADATs that Scottish Executive expectations of them were unrealistic. While the *New Framework for Partnerships on Alcohol and Drugs* was subsequently published by Scottish Government (2009c), helping to respond to the Stocktake, my findings demonstrated that confusion and ambiguity about expectations for ADPs persist. Furthermore, the findings showed variation remained within and across ADPs about what the partnership’s role and responsibilities were, and that ADP members felt expectations of them were impossible (especially given budget cuts).

Linked to both accountability and evidence use, the Stocktake recommended ADAT/ADPs should “improve the involvement of service users and put in place mechanisms to capture and act on their views.” (p. 8). My findings indicated an intrinsic motivation among many ADP members to respond to service user needs. The development of local needs assessments help them to do this, however these were not updated regularly, and there remained challenges in ensuring all ADP members were committed to using and acting upon experiential service user evidence. The most successful example (of the limited examples available) of involving service users and capturing their views was in LA2, where the ADP supported and facilitated peer research among service users. Finally, linked to evidence use and resources, Cameron (2007) recommends ADAT/ADP partners “should use existing resources to develop joint working in the sharing and analysis of local information...” (p. 9). My findings suggest sharing and combining information between partners is occurring to a certain extent. However, this appears largely dependent on individuals’ initiative, as opposed to having an institutionalised, structural process which facilitates and encourages it.

The key conclusion from the Stocktake was that partnership and coordinated / joined-up working were essential components of effectively addressing alcohol and drugs problems in Scotland. Overall, it appears that some steps have been made towards the recommendations of the 2007 Stocktake to improve the operation of these partnerships and their alcohol policy implementation work. Importantly, however, this thesis demonstrates that key challenges persist across the themes of

accountability, evidence use and resources. My research suggests a need for more careful consideration of the governance of alcohol policy implementation that takes into account complex local 'realities'. While Scotland has been heralded for developing a progressive alcohol strategy, my findings suggest that progress towards public health goals will remain limited while there continues to be a paucity of governance structures to support implementation locally.

8.6 Strengths and Limitations

In addition to methodological limitations discussed in Chapter 4, there are a number of strengths and limitations of the work which presented over the course of this research project. In relation to strengths, from a public health policy perspective, this research remained grounded in an important health policy problem (alcohol) which is related to a high burden of harms and cost within Scotland, and contributed to addressing a gap in knowledge about how and whether policy responses to this problem were being realised. I also conducted this research at a time when (i) the current strategy was well-established, leading my interviewees to be able to speak in-depth about their experiences of implementing the strategy, and (ii) in the lead-up to the publication of a 'refreshed' strategy, which would be implemented in a similar policy and legislative context, thus making my research timely and relevant for learning to be taken forward.

Methodologically, a strength of this thesis was how I accessed three local areas for my embedded case study, which provided the opportunity to investigate my research questions in different contexts across Scotland. Another strength was undertaking a high number of in-depth interviews with relevant stakeholders, who had different perspectives, backgrounds, and were situated at different levels of governance. This enhanced my ability to speak to a range of themes and their interconnections. An example of this was the ability to consider and explain how accountability and evidence use were both inevitably influenced by the partnership working context of ADPs.

A number of limitations are also evident within this research. From a methods perspective, I was able to interview relatively few LB members compared with ADP stakeholders, potentially creating an imbalance in the depth and variation of

perspectives available. To address this, I supplemented my analysis with accounts of interactions with LBs from ADP members.

As with any empirical research, my approach or analysis could have been conducted differently. First reflecting on the types of individuals and organisations with whom I generated data, the results of Chapter 5 could have been enriched by a more in-depth discussion of ADPs' relationships with their local governance institutions such as the Community Planning Partnership or new Integrated Authorities. The relative lack of data available on this was possibly a result of my research focus on Scotland's national alcohol strategy, and how my interview questions tended to focus more on how ADP members perceived their relationship with the Scottish Government. Thus, these additional, local governance relationships may be an area for future research.

Further, my approach to recruitment did not lead me to formally interview any Licensing Forum members, because my engagement with policy documents and my snowballing from interviews did not suggest Forum members were involved in local implementation decision-making. For informational purposes, I did attend a Forum meeting and had an informal discussion with a Forum chair, which helped confirm this. However, having gone on an analytical journey that led me to develop a greater focus on LB accountability, I now recognise that interviews with Forum members may have positively contributed to my understanding of this potential accountability relationship.

Additionally, while I interviewed members of the third sector in their capacity as representatives on each ADP, I acknowledge that this small number of interviews would not have captured the diversity of third sector organisations working at local level to deliver alcohol services. This reflected my decision to maintain focus on the strategic, policy-focused, decision-making level of local governance evident at the level ADPs were working within. I perceived that it would not be feasible (given time and resources) nor warranted (given my research focus), to pursue interviews with third sector service delivery organisations individually. I did, however, interact on an ongoing basis with AFS (a key, national-level third sector organisation) to discuss aspects of my findings (especially my understanding captured in Chapter 2). As with

all research, these decisions were informed by time and resource capacity, and while not possible for this thesis, offer directions for future research.

Ideally, I would also have been able to capture in more depth aspects of the broader policy and legislative context which were influencing the working structure of ADPs, particularly what was happening as a result of 'health and social care integration' (see *Public Bodies (Joint Working) (Scotland) Act 2014* in Chapter 2). However, the novelty of the legislation during my interviewing period meant key changes were still in flux at that time, making the data I generated about this contextual change mostly characterised by a sense of uncertainty.

8.7 Directions for Future Research

The findings in this thesis point to multiple avenues for future research. In terms of methods and approach, it has been noted that making more effort to include other relevant stakeholders, such as third sector organisations, who contribute to local policy decision-making in future research on Scottish alcohol policy implementation may provide access to important perspectives. Further, while there were built-in comparison elements in the analysis, I did not take an explicitly comparative approach to studying the three local areas. This followed my decision to take an embedded case study approach, in which I wanted to synthesise the data I had from across the three areas in order to speak to their accountability regimes and evidence cultures, and have time and capacity to also consider the role of LBs. In future, an explicitly comparative approach may provide the opportunity to tease out differences and diversity across local areas. This would be important for forming recommendations that were conducive to policy implementation while also acknowledging differences across context and place.

In policy terms, I have generated findings about accountability, evidence use, and context and resources within Scottish alcohol policy implementation. Future research could seek to investigate, for example, whether such implementation challenges are similarly evident across other health policy spaces in Scotland like physical activity, smoking, or nutrition policy. These policy areas may be of interest due to (possible) similarities in issues related to the complexity of behaviour change, and the impact of social, economic, and political contexts. This future work may be

of particular interest in health policy spaces where cross-sectoral, local partnerships have been established to implement these types of health policy, and where policy coordination, coherence, and integration have been established/are needed to address complex health problems.

Results which showed public health evidence often did not fit well with either ADPs or LBs needs for locally contextualised evidence may wish to be critically considered by public health researchers who aim to influence policy and practice. This was particularly evident in terms of how the drive for decontextualized, generalisable research results within public health contravened the need for locally relevant, contextualised learning expressed by interviewees. Learning from existing evidence and policy scholarship which recognises, for example, the inherently political nature of policy and legal contexts in which research is only one consideration during decision-making may usefully inform future work to reconcile these different evidence cultures (e.g. Zane and Welsh, 2018). Following on from this, work which provides lessons for how to institutionalise evidence use, or develop systems for the 'good governance' of evidence (Hawkins and Parkhurst, 2016; Liverani et al., 2013) may also be useful.

Considering this research in the context of wider themes such as community engagement, recent qualitative research on 'publics' in alcohol and other drug policy (in Australia and the UK) has demonstrated the importance of examining more closely these public(s) and understanding their relationships to alcohol and drug policy (Fraser et al., 2018). My findings support this, and my research was the first time (to my knowledge) that research has explicitly considered whether and how ADPs are/should be accountable to the public. However, more detailed examinations of how and whether the recent Community Empowerment legislation has become more influential in alcohol policy implementation locally remains an important avenue for future research. For example, Part 10 of the Community Empowerment Act 2015 seeks to enable people "to have their say in decisions that affect them" (Scottish Government, 2017j, p. 7). This may lead to greater support for members of the public making representation at LB meetings. However, it remains unclear whether the Act will stimulate greater weight being given to public representations, and whether LBs will be required to more firmly base their decisions on public input.

Finally, implementation of the Scottish Government's 'refreshed' alcohol strategy (Scottish Government, 2018a, 2018b) in late 2018 provides opportunities to explore how and whether the learning from this thesis could be useful in the current alcohol policy context. Future research could again be meaningfully informed by Cejudo and Michel's (2017) framework which discusses policy coherence, with a view to assessing whether coordination, coherence, and integration of policies and practices have been achieved with respect to this new strategy.

9 Conclusion

Alcohol use is a major risk factor for ill-health and a contributor to health inequalities. Scottish alcohol-related mortality rates are the highest in the UK, with the greatest burden of alcohol-related harm falling on people from the most deprived areas. This thesis provided an investigation of local implementation of the 2009 Scottish alcohol strategy which was designed to address this.

Chapter 1 introduced the topic area and highlighted that the Scottish Government has been ambitious in their policy and legislative efforts to addressing the problem, but that alcohol-related harm and demand for services remain high (as do the costs of each) (Audit Scotland, 2019; Giles and Robinson, 2019). Further, while significant money and effort have been expended researching national-level overviews of Scotland's alcohol strategy and implementing MUP, much less is known about how the strategy as a whole was being implemented at local level. Given the persistently high rates of alcohol-related harm and the relative paucity of research examining local implementation of the strategy, this chapter outlined how the thesis aimed to contribute understanding about how implementation occurred and elucidate challenges facing the local policy actors tasked with this work.

To contextualise the analysis in this thesis, Chapter 2 mapped the multi-level policy, legislative, and institutional landscape which surrounded its development and implementation. Next, Chapter 3 presented a systematic review of existing literature on alcohol policy implementation in high-income contexts. This was done in order to provide a focused account and critical engagement with the literature in which this thesis is situated (and is the first known review of this literature), and inform the development of my research questions. A key finding from the review was the identification of factors which can be facilitators or barriers to alcohol policy implementation: performance measurement, partnership working, public involvement, resources, and evidence use. Synthesising these factors further, the review identified important research gaps particularly related to: (i) how accountability relationships are situated in the context of multiple other, overlapping accountability relationships; and (ii) how evidence is perceived and used at organisational-level and in partnership contexts. These gaps informed the development of the thesis' two research questions. Additionally, issues related to

context and resources appeared in the review as being intertwined with other aspects of implementation. Therefore, those factors were taken forward as a cross-cutting theme across the thesis.

The methods for the thesis were discussed in Chapter 4. To undertake data generation and analysis, this research took an interpretive, qualitative, embedded case study approach with three purposely selected local areas across Scotland. Within this approach, 63 semi-structured interviews (at national and local level) and documentary analysis of 16 documents were utilised to generate data. The data corpus was analysed thematically, and the empirical chapters were written to focus on the themes identified in the systematic review.

The first research question was addressed in Chapters 5 and 6, explaining how implementation of Scotland's 2009 alcohol strategy was influenced by formal and informal accountability mechanisms in the contexts of ADPs and LBs, respectively. Both chapters used Hupe and Hill's (2007) accountability typology to organise the data. Chapter 5 usefully adapted the typology to the Scottish alcohol policy implementation context by adding 'partnership' to the typology's conceptualisation of 'professional accountability', in order to better fit with ADPs' structure.

Chapter 5 first demonstrated that ADP members' perceived their accountability regime to be characterised by confusion, complexity and miscommunication. The chapter showed this was a consequence of members' perceptions that their accountabilities are often overlapping and sometimes in conflict with one another. Further, that ADP members perceived they were accountable for activities for which they did not have commensurate resources or authority, and that communication from the Scottish Government about their accountability-related responsibilities often lacked clarity or consistency.

Chapter 6 presented analysis which has been published in the peer-reviewed literature (Wright, 2019), showing that LBs operate within an accountability system that is distinct from, and sometimes in tension with, the system for ADPs. Consistent with existing literature (Fitzgerald et al., 2017) LB members reported greater prioritisation of economic concerns over public health ones, which had implications for their licensing decisions, and consequently, for local alcohol availability. This

chapter provided new explanation and understanding about why this prioritisation occurs. It found that legal accountability is the sole formal accountability mechanism acting upon LBs, and argued that, consequently, LBs' accountability regime did not sufficiently ensure LBs contribute to the public health goals of the Scottish alcohol strategy. Together, Chapters 5 and 6 provided the first known in-depth analysis of the accountability regimes of ADPs and LBs. They demonstrated that analysis of these regimes can help to identify and explain key challenges in for Scottish alcohol policy implementation.

The second research question was addressed in Chapter 7, regarding the role of evidence in implementing Scotland's 2009 alcohol strategy. The chapter directly built upon a suggestion by Fitzgerald and colleagues (2017) that there may be 'cultures of evidence' among local alcohol policy implementers. The findings demonstrated evidence does play an important role in local decisions among both ADP and LB members and confirmed that distinct 'cultures of evidence' (Lorenc et al., 2014) among these organisations could be observed. My analysis therefore provided a focused examination of why there has historically been 'epistemological discord' (Nicholls, 2015) between these types of actors, ultimately interpreting and explaining that ADP and LB cultures of evidence had key similarities and differences. It was posited that these findings help explain why interactions between these two organisations, particularly with respect to public health evidence and policy goals, remain challenging. It also suggested that public health researchers who wish to influence Scottish alcohol policy implementation may benefit from doing more to understand local organisations' respective cultures of evidence (and their implications for local implementers' evidence needs).

The thesis also considered how contextual factors and resources appear to shape the local implementation of Scotland's 2009 alcohol strategy, discussing these throughout Chapters 5-7. The findings suggested the funding structures (and significant budget cuts) and governance approach to supporting ADPs are currently influencing and presenting challenges for their partnership working, accountability, and evidence use. It was also clear that LBs' concern with the local economic and financial context influenced their own decision-making. These findings help to confirm understanding from existing alcohol-focused and broader public policy implementation literature about the importance of context and resources (Chalmers

et al., 2016; Fitzgerald et al., 2015; Hill and Hupe, 2014; Howlett, 2018; Parkes et al., 2011), but add understanding about how this may influence their accountability regimes and cultures of evidence, with consequences for their implementation work.

The Discussion, presented in Chapter 8, brought together the key findings to articulate challenges related to multi-sectoral collaboration, in particular through discussion of partnership working and policy coherence. It was emphasised that effectively overcoming implementation challenges observed in Scottish alcohol policy implementation may require rethinking about alcohol policy governance 'architecture'; what this may look like is an important topic for future inquiry. These findings, and those from the thesis overall, help demonstrate the utility of drawing on broader literatures such as policy implementation, accountability, evidence and policy, and partnership, for the purposes of analysing alcohol policy implementation.

Having made the above contributions to knowledge about alcohol policy implementation, this thesis has provided important learning for the practice of alcohol policy implementation in Scotland. Indeed, this thesis shows that while Scotland has been ambitious in trying to give primacy to public health concerns in their overall strategy, the reality of how it has been implemented reveals a multitude of challenges. The identification and analysis of these challenges may be useful for policy actors from other UK contexts to consider. For example, should UK policy actors (e.g. in England/Wales) respond to calls from certain local and public health groups for a public health objective (e.g. see Foster, 2016, p. 196; and Martineau et al., 2014), these findings suggest it would be naïve to assume that simply adopting this objective will impact on decisions. Rather, any such change ought to be accompanied by efforts to consider what might enable effective implementation. With consideration of accountability, evidence use, and context and resources, this thesis has shown that even progressive, evidence-informed alcohol policy needs to be underpinned by well-considered governance approaches that support local implementation.

A final reflection: since September 2019 I have been working as a civil servant with the Scottish Government, having taken on a role in which balancing, considering, and making sense of complex cross-sectoral policy issues are critical to my own day-to-day policy work. At time of submission of this thesis, I am working in the

Private Office of Scotland's Chief Medical Officer during the Covid-19 outbreak. In this role I must continually and rapidly reflect on the interface between research and policy – especially in terms of how this interaction is realised in highly-pressured policy practice. The skills I gained in the course of doing this research are helping me to operate in this new role, including how to navigate complex networks of research and policy professionals, gain access to key spaces and stakeholders, analyse data, and communicate my ideas, findings, and interpretations to others.

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APPENDIX 1 – Framework For Action, Analysis of Action Levels

Proposed Actions from the 'Framework for Action'

The policy document 'Changing Scotland's Relationship with Alcohol: A Framework for Action' has been discussed throughout this thesis. The table below depicts the range of specific proposals for action contained within that policy document, and an assessment of whether they are expected to be implemented at UK, Scottish, local level, in multiple levels, or whether it is unclear from the document's representation of the proposal for action.

Framework for Action: Proposed Actions and Indicated Level of Implementation

Proposal	Level of Implementation	Clarifying Notes
Reduced Consumption		
1. Regulations should be made under Licensing (Scotland) Act 2005 to put end to multi-buy deals and preventing sale of alcohol as a loss leader	National	
2. Introduce minimum retail pricing	National	
3. Support introduction of legislation to require licensed premises to offer measures of 125ml of wine and 25ml measures of spirits	National and UK	Government will regulate to make it a condition of premises licenses that wine be available in 125ml measure. Spirit measures are governed by UK legislation, Government states it will push UK legislative change.
Supporting Families and Communities		
4. Youth Commission will explore the issues faced by young people in relation to misuse of alcohol beginning this spring and will report back with advice on actions which might be taken to address the issues they identify.	Unclear	Young Scot asked to establish Youth Commission to explore issues faced by young people in relation to misuse of alcohol. Unclear from policy whether this is national, regional, or local initiative.
5. Review current advice for parents and carers around alcohol and associated issues	Unclear	While review itself may be at national level, responsibility for the integration of advice to parents with Government's early years framework, and enactment of this programme of work, is unclear.

<p>6. Legislate to:</p> <ul style="list-style-type: none"> • Place duty on Licensing Boards to consider raising minimum age for off-sales purchases within their area to 21 • Enable Licensing Boards to apply such a condition without requiring a hearing in respect of every premise concerned • Give the Chief Constable and the Local Licensing Forum powers to request that the Licensing Board consider the matter of an age restriction at any time 	National and local	Government will legislate to place the relevant duty on Licensing Boards, however other related actions, and the enactment of this legislation will be local, by virtue of it placing duties on Licensing Boards.
7. Establish legislative power to apply a Social Responsibility Fee	National	
8. Survey of incidence of Fetal Alcohol Syndrome in Scotland	Unclear	Policy states this review was occurring in collaboration with range of stakeholders. Unclear who is responsible for completing survey or acting upon findings.
9. Work with our partners at national and local level to improve substance misuse education in schools. A workplan has been developed with tasks designed to lead to better partnership working, improved support for those delivering teaching, and better awareness of the available teaching resources, to be implemented before the end of 2010.	National and local	
10. Support third sector organisations to provide youth work and/or diversionary activities	Local	Although this proposal included statements of investment made by Government, the delivery of these initiatives will be local.
11. 'Promoting Citizenship through Football - A Government and Football Partnership' to identify and take forward opportunities for joint working with football on tackling alcohol misuse.	National and Unclear	Established working group in partnership with other national-level public and private sector organisations. Work of this partnership appears to be national-level, given it comprises the Scottish Government, sportscotland, the Scottish Football Association, and others who work at national level.
12. A Project Board has been convened to drive forward work on improving identification and assessment of those affected by parental substance misuse and sharing of appropriate information amongst agencies; and building capacity, availability and quality of support services.	National and local	Government identifies that its own officials will 'drive forward progress on this agenda'. However, identification and assessment of those affected by parental substance misuse, and enhancement of support services, will necessarily have to occur at local level.

13. Will continue to work through the Scottish Government-led Scottish Age-restricted Products Enforcement Working Group, which has representatives from all key interests including the licensed trade and hospitality sector, ACPOS, and the Crown Office and Procurator Fiscal Service, to identify any further steps which might be taken to ensure effective compliance with and enforcement of licensing laws.	National and local	
14. We will undertake a review of how test-purchasing has been implemented in order to identify any lessons which can be learned and shared.	Unclear	Although the policy says 'we', indicating the authors of the policy, it is unclear where responsibility lies for the learning and sharing of lessons.
15. Work with Young Scot to further promote the Young Scot National Entitlement Card and to bolster its use and recognition as a proof of age card.	National	
16. Increase our funding for the Best Bar None scheme, to enable this to be extended more widely across Scotland.	Local	Although Government is identified as increasing funding for this initiative, responsibility for the extension across Scotland must be located at local level.
17. Working with local partners in Fife to pilot and evaluate a package of interventions in different locales, drawing on the experience of other partnerships, as well as social norms approaches. We hope that, in due course, the experience and lessons from the Fife pilot will be able to be drawn upon by other areas and adapted for their local circumstances.	Local	
18. Discussions are on-going about the scope for trading standards officers to be given a role, alongside the police, in enforcing licensing law in relation to off-sales and, specifically, in programmes.	Local	
19. Develop sustained and tough enforcement measures such as the Safer Streets initiative, where we have provided over £2 million to Community Safety Partnerships to deliver extra initiatives to tackle alcohol related violence and disorder over the festive period. We will also continue to support education initiatives such as Medics Against Violence, which involves a number of senior clinicians working with the Violence	Local	Responsibility for curbing alcohol-related violence located with Community Safety Partnerships.

Reduction Unit to raise awareness amongst young people of the dangers of carrying a knife.		
20. Focus on early intervention through the Community Initiative to Reduce Violence (CIRV), the ground-breaking gang's initiative to tackle collective violence in the East End of Glasgow.	Local	
21. Publish a research report, which will set out a range of approaches that could be used across Scotland to support drunk and incapable adults. We will arrange an event for stakeholders to disseminate the findings and encourage the assessment of needs and development of appropriate approaches at a local level.	National and Local	Publication will occur in public domain, and event at national level planned, however resultant actions seem to be required at local level.
22. Reduction in the drink driving limit and the introduction of new police powers for random breath testing.	National	
Positive Attitudes, Positive Choices		
23. Bring forward regulations that will restrict display of marketing material relating to alcohol	National	
24. Consider there is considerable scope for producers and retailers to develop, as part of a co-regulatory approach, a code of practice for promotional activity.	Unclear	It is unclear at what level of governance industry codes of practice would be decided and enacted (e.g. national chains in collaboration with Government, or local retailers, in collaboration with local Council).
25. Have decided, for the time being, not to introduce alcohol only checkouts, however we may revisit this issue if retailers do not comply with the spirit of our other actions on off sales. Given this decision, the question as to whether those operating such checkouts should be at least 18 years old does not apply.	N/A	
26. Continue to work with health and industry partners, where appropriate, on the promotion messages to help people change their behaviour, and on joint initiatives such as Alcohol Awareness Week.	National and local	Suggests that although led by national government level, that the actual dissemination of information may be at local level.
27. Continue to work with partners to develop and promote workplace alcohol policies, noting that the workplace can be a key point of connection. We will seek to apply more proactive	Unclear	Although led by Government, unclear where responsibility lies for pursuing this action.

management-led workplace programmes management-led workplace programmes on tackling alcohol misuse, starting from Government, with a view to rolling out action across the public sector and encouraging similar action in the private sector.		
28. Alcohol product labelling could be significantly improved and we are discussing with the UK Government how this could be taken forward.	UK	
29. We urge the UK Government to develop a UK approach to advertising which unequivocally protects children from exposure to alcohol advertising, whether on television, on line, or in the cinema.	UK	
30. We would welcome the development of a co-regulatory approach to online alcohol advertising - working with industry, the UK Government and advertising regulatory bodies, which could address this issue effectively. Could also extend to billboard advertising.	UK	
31. Monitor the implementation of the Scottish Government and Alcohol Industry Partnership Sponsorship Guidelines and consider whether further action is required	Unclear	Unclear who is responsible for monitoring implementation (whether it will occur at national level, or occur locally and be reported to national level). Additionally, the implementation itself may be more local.
Improved Support and Treatment		
32. Record investment towards tackling alcohol misuse in our 2008/09 budget, totalling £120 million over the next three years. This represents an increase of over £85 million to previous allocations. This is in recognition of the need for greater effort on prevention, in particular the delivery of screening and brief interventions. Our aim is to make such screening and early intervention part of the routine services offered by NHS Scotland	Local	This point is framed more as a statement than an action. However, the 'action' is interpreted as enhancing the delivery of screening and brief interventions, which occurs at local level.
33. Establish a working group to update core services or alcohol treatment and support. This will re-visit the principles underpinning the Alcohol Treatment Services Framework;	National and local	

identify and update effective interventions; and set out guidance on development of integrated care pathways which take into consideration multiple and complex needs.		
34. Support the evaluation of brief interventions pilots in other settings or which can contribute in other ways to the evidence base. Initially pilots already being taken forward are in NHS 24 and the area of criminal justice.	Local	
<p>35. We have set up a national Delivery Support Team to provide leadership to NHS Boards on the delivery of the target and to co-ordinate key support functions. This Team will work to support NHS Boards providing help, advice and guidance as necessary.</p> <ul style="list-style-type: none"> We have begun a programme of visits to NHS Boards to hear feedback first hand on progress, identify good practice and offer further individualised support where appropriate. We will hold a conference for NHS Boards in 2009 to demonstrate distance travelled and share good practice. 	National and local	While framed in terms of national government actions, this speaks to service delivery by local (regional) NHS Boards.
36. To support NHS Boards in achieving the new target for brief interventions we have commissioned NHS Health Scotland to develop and coordinate a 3-year national training programme to ensure that frontline staff across the country are competent and confident in the delivery of brief interventions. Thereafter we will ensure that training on brief interventions is recognised as a core aspect of workforce development in NHS Scotland.	National and local	
37. Scottish Government is currently considering the Delivery Reform Group's (a subgroup of the Scottish Ministerial Advisory Committee on Alcohol Problems) proposals on reform of Alcohol and Drug Partnerships with a view to making a statement on the way forward as soon as possible.	National and local	
38. We have commissioned NHS Health Scotland to drive forward a piece of work to create a national training and development strategy to support a competent, confident, valued and flexible workforce.	National	

<p>39. Forthcoming Action Plan for population mental health improvement, <i>Towards a Mentally Flourishing Scotland</i>, to be published in Spring 2009, will recognise the relationship between alcohol and mental health. Where appropriate this relationship will be a key feature of related actions and commitments.</p>	<p>Unclear</p>	<p>Development of the Action Plan itself is at national level, however enactment of components of the Action Plan will be dependent on each component.</p>
<p>40. Explore the opportunities for developing psychological therapies as a generic form of behavioural change intervention which can lead to positive outcomes not only for those with mental health issues but also for those with co-morbidities arising from alcohol and drugs misuse.</p>	<p>Unclear</p>	<p>Unclear who is intended to 'explore' these opportunities.</p>
<p>41. In 2009, we will conduct a review of current plans and practice for the identification and treatment of offenders with alcohol problems in criminal justice settings and identify good practice.</p> <ul style="list-style-type: none"> • We will also convene a stakeholder event to disseminate the findings of this review and agree action on how best to ensure development and implementation of integrated care pathways for offenders with alcohol problems. 	<p>National and local</p>	<p>Actions are framed in terms of what Government will do to support aspects of developing an integrated care pathway for offenders. However, description in policy notes that Community Justice Authorities have key part to play, in partnership with the Scottish Prison Service and those who provide community based services.</p>

APPENDIX 2 – List of Scoping Interviews

Appendix 2: List of Scoping Interviews

The below table lists the names, organizations and roles of people with whom informal scoping interviews were held during the research design phase of my PhD research project.

Name	Organization	Role
Amanda Adams	Scottish Government	Alcohol Policy Team
Clare Beeston	MESAS	Head of MESAS
Biba Brand	Scottish Government	Alcohol Policy Team
Pippa Coutts	Alliance for Useful Evidence	Scottish Lead
Gemma Crompton	Alcohol Focus Scotland	Policy and Development Coordinator
Jennifer Curran	Alcohol Focus Scotland	Acting Chief Executive of AFS
Phil Eaglesham	NHS Health Scotland	Health Improvement Programme Manager, Alcohol and Drugs
Louise Feenie	Scottish Government	Alcohol Policy Team Leader
Vittal Katikireddi	NHS Lothian & University of Glasgow	Researcher
Kirsty MacDonald	Scottish Government	Alcohol Policy Team
Iain McAllister	Scottish Government	Principal Research Officer (Public Health), Health Analytical Services Division
Gerry McCartney	MESAS	Data analyst
Hilary Scott	Scottish Government	Alcohol Policy Team
Jim Sherval	NHS Lothian	Consultant in Public Health; Chair, Edinburgh ADP Joint Commissioning Group
Nicholas Smith	Edinburgh Council	ADP Manager
Erica Wimbush	NHS Health Scotland	Head of Evaluation (now retired)

APPENDIX 3 – SPICe Briefing (Wright, 2017)



The Scottish Parliament
Pàrlamaid na h-Alba

SPICe

The Information Centre
An t-Ionad Fiosrachaidh

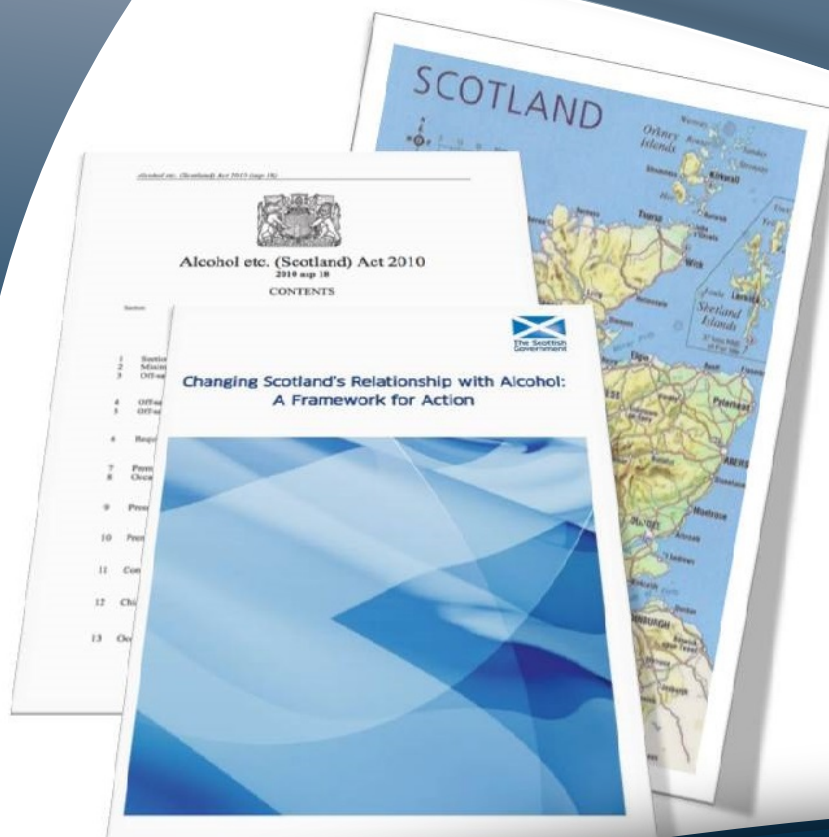
SPICe Briefing

Pàipear-ullachaidh SPICe

What's so important about health policy implementation?

Alex Wright

This briefing has been written by Alex Wright (University of Edinburgh & What Works Scotland) during an Academic Fellowship with SPICe. The briefing reviews evidence about how health policy is implemented. Whilst the briefing focuses on alcohol policy, it may be useful for a wider range of health and public policy areas. The evidence in this briefing has drawn together key lessons about policy implementation to support scrutiny.



7 September 2017
SB 17-62

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Executive Summary

Effective implementation is critical to the success of health policies and legislation. Even when a policy or piece of legislation is of a high-quality, incomplete implementation may lead to policy failure, resulting in unintended population health consequences and ineffective uses of public resources.

Planning for effective implementation is therefore an important consideration during the development, review, and scrutiny of policy and legislation. Based on the evidence in this briefing, a number of questions could be raised during scrutiny. These questions are broadly aligned with the themes discussed in this review.

PLANNING FOR EFFECTIVE IMPLEMENTATION: KEY QUESTIONS TO ASK DURING POLICY SCRUTINY

- What ongoing **administrative and leadership support** will be committed for the implementation of this policy?
- Is it clear from the policy (and/or associated guidance) which individuals or organisations are **accountable** for its activities, interventions, and intended policy outcomes? (i.e. who are the policy implementers?)
 - Do the individuals, organisations, or partnerships identified have the authority, legitimacy, and resources to carry out this work?
- Are there **clear and transparent funding** mechanisms in place? Is the funding provided **sufficient/sustainable** for the period of time required?
- What **other resources** beyond funding will be provided to support implementation? (e.g. training, recruitment and retention of qualified personnel)
- To what extent have all or some **stakeholders been meaningfully involved** in formulating the policy and policy implementation plan?
 - Is there buy-in from these stakeholders?
 - Is there a plan to continuously engage with stakeholders during all aspects of policy implementation, review, and reform?
- Is there a **plan in place to evaluate** the process and outcomes of this policy? If so, are there sufficient resources allocated to this? (Including systems to collect, collate, and use good quality monitoring data)
 - Is there a plan (and resources) for resulting data to be used to inform improvements?
- Have (a) **potential threats** to sustainable implementation, and (b) potential **unintended consequences** of the policy been identified, and have plans been developed to mitigate these before they occur?

I. Introduction

The implementation of a policy is an integral part of the policy process.^{1 2} Once a policy has been developed, or a policy decision has been made, it must be enacted if it is to have any impact on the intended population. Even good, evidence-informed policies cannot have their intended effect if not implemented properly.

It is well known that there are a number of challenges when implementing national health policies. Evidence demonstrates that these challenges often lead policies to be enacted in such a way that they are only implemented partially or diverge from the original aims of the policy. This can result in an 'implementation gap' between the policy goals and outcomes or even lead to policy failure.

In an effort to understand how policy implementation occurs and how it can be improved, a great deal of research has studied this topic. This evidence provides suggestions for policy decision-makers at national and local levels to close the implementation gap. This briefing will discuss key concepts for effective health policy implementation, with alcohol policy in Scotland presented as a key case study. Although health and alcohol policy are the focus, lessons from this review will be applicable to a wider range of health and public policy areas.

Why is health policy implementation important?

- If policy implementation is ignored during policy formulation and scrutiny, stated goals and intentions of a policy, including positive population health changes, will not be achieved
- Incomplete policy implementation, or policy failure, may result in unintended population health consequences and ineffective use of public resources

About this evidence review

This review has been developed in a specific effort to be useful and applicable to the work of MSPs and other stakeholders who are engaged in the task of analysing and scrutinising government policy during policy development, review, and reformulation.

This briefing is a review of evidence regarding health policy implementation. It draws on peer-reviewed journal articles and grey literature on a variety of health policy topics, including health and social care, health inequalities, disability rights, indigenous health, mental health, physical activity, obesity, and tobacco control. There is a specific focus on alcohol policy in Scotland.

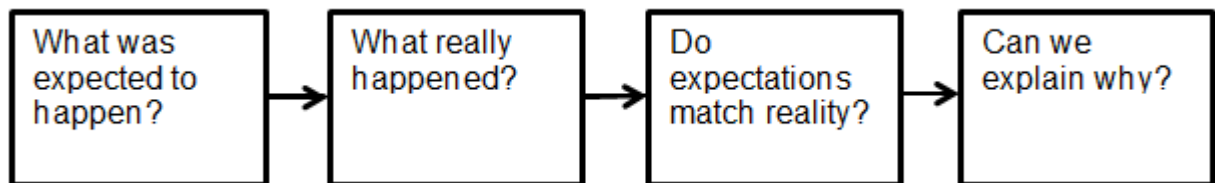
What is policy implementation?

“ Policy implementation is what develops between the establishment of an apparent intention on the part of government to do something, or to stop something, and the ultimate impact in the world of action. ³ ”

The above is a useful definition of policy implementation. However, as a complex concept, policy implementation has been defined differently by different researchers. When defining policy implementation, researchers often focus on particular aspects of the concept, for example: ^{4 5}

- *whether implementation occurred* and if it is considered to be complete;
- what was the *process of implementation*, and how could it be improved; and/or
- whether the policy *outcomes match expectations*.

Some basic questions to ask when reviewing and scrutinising the implementation of a particular health policy may include:



II. Evidence on Health Policy Implementation

The sections below discuss key topics from existing health policy research that can act as barriers or facilitators to policy implementation.

1. Planning for Policy Implementation

Existing research confirms that planning for policy implementation is **best conducted during the stage of policy formulation and scrutiny** – to a certain extent, the success of implementation is a function of how the original policy or legislation is developed.^{6 7}

For example, an [Audit Scotland report](#) on the integration of Health and Social Care found that although integration was expected to be operational by 1 April 2016, implementation challenges in the planning stages put this deadline at risk. Challenges such as disagreements over budgets and uncertainty over funding delayed the development of local strategic plans.⁸

Poor planning may lead to issues such as insufficient numbers of trained staff or resources to handle the burden of managing a new policy.⁹ A lack of planning may also increase the risks of unintended consequences.¹⁰ For example, a study of disability rights legislation in Sweden found that the legislation was interpreted narrowly at local level during implementation, leading to the exclusion of people with mental health problems, and government clarification about this issue was never provided.¹¹

In terms of planning for implementation, many health policy topic areas are complex and require a multi-sectoral approach. In Scotland, the response to this has been a commitment to partnership working.¹² During planning for how policy implementation will occur in partnership settings, it is advisable to consider utilising pre-existing organisational expertise. Research indicates that organisations which already conduct work on a given health topic (e.g. 'health equity') may be better positioned to more easily implement new initiatives on that same topic.¹³

In addition, the context of a local area will specifically shape how a given policy is implemented in that area – this interaction will influence policy outcomes.¹⁴ It is self-evident that one-size will not fit all. Existing evidence suggests that certain contexts can be more receptive to certain policies and approaches to implementation than others.¹⁵

Opportunities for further planning also exist during [impact assessments](#), when the impact of policy or legislation on issues such as finances or equality are assessed.

KEY POINT: Insufficient planning for health policy implementation may lead to otherwise avoidable challenges to a policy being operationalised.

Brief example: Planning

In a study which reviewed a number of health policy initiatives in the city of Chicago in the United States, researchers found approximately 70% of initiatives had limited or no progress towards implementation. These researchers found that certain aspects of policy design acted as barriers to implementation, including: the provision of limited information on the policy problem; providing broad recommendations for implementation without specific direction; and variations in public consultation or involvement.¹⁶

2. Resources

A clear message from existing evidence is that policy implementation requires a variety of resources to support the process.^{17 18 19 20} These include, but are not limited to financial resources, human resources, leadership, and infrastructure. A lack of necessary resources may result in incomplete policy implementation or policy failure.¹⁷

2.1 Financial Resources

The issue of financial resources is directly linked to the other themes in this briefing. For example, human resources, conducting consultations, maintaining infrastructure, and sustaining performance measurement and evaluation require financial support.

Evidence shows that a lack of, or uncertainty about, financial resources is a critical barrier to policy implementation and, vice versa, successful policy implementation relies on appropriate monetary support.^{21 8 22 23} For example, policy implementation can be put at risk if no extra resources are made available when a new, additional policy is required to be implemented.²⁴ Further challenges arise when policy implementers are unable to reallocate existing funding or to source new funding.¹⁶ For example, researchers investigating the implementation of a care programme for people with a dual diagnosis in England found that implementing organisations were significantly constrained in undertaking this work because of financial pressures and budget cuts.²⁵

In light of this, there is consensus within existing literature that sufficient, dedicated, sustainable funding greatly facilitates policy implementation.^{26 27 28 29}

KEY POINT: Health policy implementation must be adequately and sustainably financed.

2.2 Human Resources and Training

The availability of skilled, knowledgeable staff is important for policy implementation.^{30 10}
¹³ Ensuring sufficient numbers of staff and the right skills require additional recruitment and training for policy implementation and managing staff turnover.

A key human resource challenge is staff turnover and position instability, which can result in the loss of institutional memory and valuable experience.^{13 25} Ways to retain staff may therefore need to be prioritised, for example by supporting policy implementers (including managers and service providers) by providing resources to advise and assist them with specific policy, legal, and regulatory processes.³¹

The lack of time that existing staff have to allocate to implementing a new or refreshed policy is frequently cited as a problem.²² Given that staff are often trying to cope with competing priorities at local level¹⁷, it is likely that direction and support must be given about how they should prioritise any new initiative.

There is a consensus about the need for training to equip policy implementers, particularly at early stages of policy implementation and then in an ongoing capacity.^{32 19 7 23 28 13 31} Investments in training may be required for newly created roles, for example a new category of public health professional¹³ or new interventions, such as the use of new naloxone kits to be used in the event of drug overdose.¹⁹

A lack of adequate training and staff capacity building is a barrier to policy implementation.^{22 23 33} For example, researchers examining the implementation of a care programme in the UK found that certain social service staff were unable to access training, and that this was a challenge to the implementation process.²⁵ In another example, local implementers of a health service in Australia felt that Indigenous health workers were not provided with adequate training (or authority) to influence decision-making in the policy implementation process.³³ Taken together, this suggests that different types of training may be required in policy implementation, including a) technical content to deliver policy activities, and b) training in engaging with the policy process for broader stakeholders.

KEY POINT: The availability of skilled, knowledgeable staff who are offered ongoing training is important for health policy implementation.

Staff turnover (with associated loss of institutional memory) and position instability can be key challenges to this.

Brief Example: Training

In an analysis of the implementation of the Licensing (Scotland) Act 2005,³⁴ researchers noted the consensus among interviewees that training had increased the knowledge and standards of practice among multiple stakeholders in the Scottish alcohol licensing system. These authors also note, however, that where training is required to facilitate policy implementation, it is helpful for it to be both mandatory and monitored to ensure it is complied with.

2.3 Leadership, Commitment, and Ideology

In addition to having sufficient human resources, it is important to consider aspects of leadership, levels of commitment, and ideologies that may influence how stakeholders undertake policy implementation.

Effective policy implementation requires ongoing support from national and regional governments and organisations, as well as relevant individuals.^{28 13} Since a lack of leadership can be a barrier to implementation, existing evidence suggests identifying and supporting local and regional leaders (or “champions”) to drive implementation processes.^{22 35 25 31} These leaders can provide guidance on what policy activities are valued and can influence the general culture towards a policy topic (e.g. beliefs surrounding domestic violence).⁷

Buy-in from local or 'front-line' policy implementers, target populations (and their representatives), and commitments from third sector organisations are also important.^{7 20} For example, if local staff believe a given policy initiative is too broad, their implementation efforts to enact it may be lessened.¹³ In a study of community nursing policy in Scotland, researchers found nurses did not feel ownership over the policy or the changes that were being implemented – this manifested as resistance to the policy.²⁰

Getting sufficient levels of commitment and buy-in for policy implementation may require incentives to get staff to engage in the process.²⁵ It can also be enhanced by engaging with staff and stakeholders from the beginning of policy development, as discussed below.

It will also be important to consider the ideologies of those who will need to implement the policy. Maycraft Kall (2014)¹¹ discusses the role of government and key organisations in shaping the ideology surrounding policy and legislation – that it is not just the ‘letter of the law’ that matters, but also the ‘spirit’ of it, something that is signalled by the national government.

For example, ideologies of practitioners who ultimately deliver a policy will influence how that policy is represented to the public who access the policy's associated services. An example of this is highlighted by O’Sullivan (2015),³⁶ who discusses the work of practitioners who deliver health services to Indigenous Australians. The authors observe that practitioners exercise discretion in service delivery, and make choices about the care that is made available to particular client groups. These choices are influenced by personal political values, such as perceptions of their client groups, and can have a significant impact on how that service is experienced by service users.

KEY POINT: Health policy implementation requires commitment from people in leadership positions, buy-in from all relevant stakeholders, and consideration of the values and ideologies of those who will implement the policy.

Brief Example: Leadership

Researchers examined Primary Stroke Care policy implementation in four US States (Florida, Massachusetts, New Mexico, and New York).³¹ Over 100 interviews were conducted with policy stakeholders, and in all States interviewees talked about the importance of 'champions' for successful policy implementation.

The researchers state: "These champions often have varying backgrounds with experience in areas, including politics, public administration, and clinical expertise; the champions all possess knowledge of policy processes and knowledge regarding ways to influence widespread support for improved stroke care." (p. 564)

In this case study, it was argued that policy implementation was facilitated by the ability of these champions to motivate and focus stakeholders on key issues, coordinate several public health agencies, and take into account health care regulation issues.

2.4 Infrastructure

Infrastructure for policy implementation can include specific equipment such as IT systems or organisational structures such as partnerships.

In terms of the role of IT infrastructure, the ability to collect and share data is an important facilitator to policy implementation and ongoing learning. Vice versa, a lack of fit-for-purpose IT systems can hamper implementation efforts.²⁵ It is therefore important to establish systems that support the collection, synthesis, and utilisation of data. For example, in a study on primary stroke care, researchers found that policies may be more readily implemented if data can be accessed and shared among all appropriate organisations and service providers, and that the ability to share patient data when required enhanced staff collaboration across the continuum of care.³¹ The importance of the use of data, monitoring, and evaluation in policy implementation is discussed in more detail below in the section on [evaluation](#).

Appropriate IT systems can also support communication and coordination across the wide range of organisations and stakeholders involved in a given policy's implementation.³¹ This may include communicating within and across systems of multi-sectoral partnerships which are a key delivery structure for delivering health policy.³⁷

If partnership working is an important aspect of a policy's delivery infrastructure, developing positive personal relationships within and across partnerships can enhance policy implementation. However, in addition to personal relationships, formal partnership agreements are also useful tools to support effective partnership working.³⁰ In relation to variables mentioned above, strong leadership, sufficient resources, and highly committed and competent staff also facilitate health policy implementation through partnerships.^{30 37}

As a final note in this section, a potential benefit of partnerships developed between health/non-health organisations and other policy stakeholders is that they have the

potential to assist local policy implementers to be responsive to local contexts and needs.

13

KEY POINT: It is critical that the implementation process of a health policy has the infrastructure to support:

(a) the collection, synthesis, and utilisation of data; and

(b) communication and coordination within and between organisations.

3. Stakeholder Engagement

Evidence suggests that relevant populations should be included in policymaking processes at legislative and regional levels to help reduce policy implementation gaps.^{31 38 13}

However, it appears that brief, one-off consultation of target populations does not guarantee more effective policy implementation. It is suggested that interactions with the target population and other key stakeholders should cover the entire policy process, from the time a policy problem is identified to policy implementation.³⁹ Stakeholder engagement can help develop a shared understanding of policy goals and the kinds of solutions that can progress towards achieving them.⁴⁰

In terms of best practice, the literature suggests that policymakers engage in meaningful involvement and discussions with other policy stakeholders.³⁹ During this, specific policy measures should be elaborated in detail so that the target population has an opportunity to consider them, and co-produced agreements about specific recommendations can be developed.³⁹

As examples from existing evidence, a study of Indigenous health policy in Australia highlighted the need for the target population to be involved at the policy formulation stage at all levels of government.²⁹ The authors advocated for increased participation of health organisations controlled by Indigenous communities in the policymaking process.²⁹

Similarly, another study examined a large federal nutrition programme in the United States, highlighting the importance of public health practitioners and policymakers engaging with the target client group, in order to learn from one another during the policy process.⁴¹

As a final example, researchers studying the implementation of a new policy to provide take-home naloxone kits in the United States found there was limited implementation of the initiative. They found that a key barrier to implementing the new policy was the lack of input from frontline health-care staff to the policy development process - it was perceived that the people who developed the policy did not understand the unique challenges faced by those who would be implementing it.¹⁹

KEY POINT: Meaningful involvement of relevant stakeholders and target populations in the *entire* policy process can help reduce policy implementation challenges.

4. Implementation Guidance and Ongoing Communication

Identification of, and communication with, responsible parties are important tasks in policy implementation. A lack of clear guidance about implementation expectations and responsibilities for policy actions can present a significant challenge from the start of implementation.^{7 34 13}

In acknowledgement of the complexity of the policy implementation process, there is a need to balance the decisiveness of implementation guidance with flexibility given to local implementers. For example, certain specific public health interventions must be delivered by trained professionals. However, allowing local policy implementers the flexibility to decide how to make this happen and to render services appropriate for local needs, may be a facilitator to implementation.³¹

Poor communication can hamper policy implementation. There is a risk of poor communication when, for example, policy implementation requires transmission and interpretation of nuanced ideas across different levels of governance or during integrated working among numerous organisations.⁴² For example, a study on community nursing services in Scotland found that a barrier to shifting care out of hospitals into the community was poor communication between the hospital and community settings.²⁰ Supporting local implementers to communicate and share practices is also noted as a facilitator of implementation.⁴³ As discussed previously, [infrastructure](#) such as IT services may facilitate communication.

KEY POINT: Health policy implementation can be facilitated by the development of clear guidance about expectations and the distribution of responsibilities for policy actions.

This guidance will be enhanced by also building in certain flexibilities for local policy implementers to adapt to local needs.

Brief Example: Guidance and Communication

Forbes et al. (2010) conducted a comparative study of health and social care policy implementation in England and Scotland. The researchers observed that in England, guidance published late led to challenges in governance and accountability, while in Scotland, existing guidance was criticised for its lack of a clearly articulated role for Councils within Health and Social Care Partnerships.²⁶

5. Organisational Culture

Organisational culture is important for policy implementation because implementing agencies have significant amounts of autonomy, and are not entirely under administrative control.¹ In addition, organisations are increasingly expected to work effectively in partnerships with other organisations that may have different values, priorities, and perspectives from their own.¹ These factors influence how organisations will interpret and undertake policy implementation. For example, organisational resistance to change, lengthy decision-making processes, risk avoidance, and lack of coordination among service providers can be barriers to implementation.¹⁶

When an organisation has been identified as the one responsible for implementing a health policy, it may be beneficial to develop or adjust organisational structures (e.g. working groups or steering committees), so that the health policy will be prioritised and given legitimacy within that organisation.¹³

To support policy implementation, international literature suggests that breaking down organisational silos can facilitate cross-organisational networking, and that planning for this should occur during policy development.¹³ This may be a key lesson for the Scottish context in which partnership working is prevalent. In this context, it is also worthwhile to consider how best to facilitate the building of strong organisational relationships and trust between partners.²⁶

KEY POINT: Planning for health policy implementation can be improved by considering the organisational culture(s) of the organisation(s) who will be involved in the implementation process.

Brief Example: Organisational Culture

A study examined a Canadian public health initiative which created new nursing roles. These new roles were focused on 'health equity' and were located in regional Public Health Units across a Canadian province.

Within each Unit, senior leadership made decisions about the early development of this new nursing role, including the scope of these nurses' new remit and where the role would be placed in the organisational structure of the Unit. As a result, a key issue arose: a lack of consistency in how the new nursing role was positioned across Public Health Units. This in turn affected key elements of the overall initiative's implementation, including the decision-making power of these new nurses, their level of independence, and how accepted they were by public health colleagues.

However, the same study found that a benefit of this flexible and adaptive approach was that the Units could learn and adapt to changing needs.¹³

6. Accountability

Accountability for enacting policy was found to be an important aspect of policy implementation quality and effectiveness.^{22 7}

A key barrier to policy implementation is a lack of clear understanding among both policy-makers and policy implementers about the distribution of responsibilities. This issue is made more complex when policies are intended to be implemented through local partnership arrangements. In an [Audit Scotland report](#) on health and social care integration, a key recommendation of the authors was to:

“ set out clearly how governance arrangements will work in practice, particularly when disagreements arise. This is because **there are potentially confusing lines of accountability** and potential conflicts of interests for board members and staff.⁸ ”

A remedy for this issue, as suggested in this quote and the above [section on guidance](#), is the development of clear, complete regulations that are disseminated and explained in advance of policy implementation. If clear guidance exists, accountability measures and enforcement mechanisms that are well-defined and formally agreed can help ensure further clarity on roles and responsibilities¹³, and therefore may enhance progress towards implementation goals. In addition, similarly to the [section on guidance](#), building a certain amount of flexibility into these agreements may help policy implementers take account of learning and, as a result, adapt implementation to changing local needs.¹³

Accountability agreements are likely to be more effective if, within them, explicit links are drawn between government goals/mandates and actions planned for local implementation.¹³ Meanwhile, a lack of incentives encouraging compliance or a lack of sanctions for non-compliance, and voluntary uptake of a policy, may be barriers to implementation.^{44 11} Enforcement of accountability may overlap with the [monitoring and evaluation](#) of policy implementation, discussed below (e.g. Allison et al. 2016¹⁷).

Another barrier to policy implementation can emerge when a new policy conflicts with other existing regulations and responsibilities.³¹ For example, a study of health and social care policies in England and Scotland found that implementation was hampered by implementers' difficulties in combining local and national performance measurement targets.²⁶

Finally, those tasked with policy implementation and held accountable for it must be provided with adequate political support and authority to undertake this work.¹⁰

KEY POINT: Accountability mechanisms surrounding a policy's implementation can be improved by:

(a) co-producing (with relevant policy stakeholders) clear agreements about responsibilities for implementation activities; and

(b) aligning responsibilities for the new policy with existing responsibilities.

7. Monitoring and Evaluation

It is important to measure and analyse the progress of policy implementation in order to know to what extent it has occurred, what successes or challenges have been experienced, and to learn from these experiences. The implementation factors discussed above can be considered and incorporated into policy planning and formulation, however it will be impossible to anticipate or completely control all aspects of implementation.⁴⁵

Therefore, a process of learning, and the capacity to continuously monitor and evaluate policy implementation, is necessary. Monitoring and evaluation is linked with the factors discussed above. For example, resources, staff capacity, and IT infrastructure must exist in order to reliably collect, synthesise, learn from, and use monitoring data and knowledge. In addition, it is recommended that planning for evaluation of implementation should be built into a policy during its development, and any core data set(s) for monitoring are agreed upon prior to policy implementation.

In Scotland, the commissioning of the [Monitoring and Evaluating Scotland's Alcohol Strategy \(MESAS\)](#) programme (discussed further below) is an example of a large portfolio of work dedicated to this task.

There is a consensus in the literature about the need for monitoring and evaluation. As an example, in a US-based study on school wellness policies, researchers found that a barrier to implementation was inadequate capacity and tools to conduct monitoring of the policy.²² Further, a study of children's continuing-care in England demonstrated the usefulness of local practitioners being able to learn from the monitoring of their programme, and then deploy their capacity to adapt it.⁴⁶ Similarly, a key conclusion from a Canadian study regarding palliative care was that policy implementation needed to be monitored *and* continuously fine-tuned.²⁷

KEY POINT: Monitoring and evaluating a health policy's implementation is a critical, ongoing process which is necessary to measure progress and provide important learning for improvement.

Key Points on Health Policy Implementation

- Planning for policy implementation should occur during policy development and scrutiny, and can support progress towards policy goals.
- Planning should include consideration of: resources, training, stakeholder engagement, organisational culture, and accountability.
- Policy implementation cannot be entirely controlled, so it is important to engage in continuous monitoring and evaluation throughout the policy implementation lifespan.

III. Case Study: Alcohol Policy Implementation

The process of health policy implementation is often studied using a case study of a specific health policy or programme. Alcohol policy was selected as the focus of this briefing, given the impact of alcohol-related harm in Scotland and its importance in Scottish health policy. This section first provides a review of international research surrounding alcohol policy implementation. A discussion of alcohol policy implementation in Scotland is then presented. Many of the themes from Section II of this review can be seen to emerge in this section.

What is known about alcohol policy implementation from international research?

"Successful implementation of national action requires sustained political commitment, effective coordination, sustainable funding and appropriate engagement of subnational governments as well as of civil society and economic operators. Many relevant decision-making authorities should be involved in the formulation and implementation of alcohol policies, such as the Ministry of Health and other relevant ministries, transportation authorities or taxation agencies." (WHO, *Global status report on alcohol and health 2014*, p. 24) ⁴⁷

As the examples below demonstrate, the international literature discusses a range of alcohol policies and programmes in terms of their implementation.

In a study of Irish alcohol policy, Butler (2009) ⁴⁸ highlights a number of challenges to policy implementation. The author argues that the **political culture** of Ireland prevented imposing strict alcohol control policies in the country. Further, it is argued that when the Irish government did create an alcohol policy based on a public health perspective, the policy's **action plan lacked the joined-up infrastructure** necessary to implement this type of policy. It was also observed that there may have been a **lack of political will** to strongly advocate for the enactment of this policy.

In a systematic review, Johnson and colleagues (2011) ⁴⁹ synthesised international qualitative evidence on implementing alcohol brief interventions (ABI). Most articles included in this study examined ABI implementation in primary care settings. The findings from this study reflect the key themes discussed in the earlier section of this review: **implementation challenges** included a lack of **resources**, **support** from management, and the high workload of ABI implementers, while **facilitators to implementation** included access to **staff training**, **staff involvement** from policy planning stages.

D'Abbs (2004) ⁵⁰ describes the implementation of an alcohol programme in the Northern Territory of Australia. In the author's view, **early implementation of the programme was successful because of factors similar to those discussed earlier in this review**: the parliamentary authority given to the programme; the political commitments made to the programme by Chief Minister; the establishment of a Trust Fund to provide sustainable

funding; establishment of intersectoral administrative capacity; and alignment of programme goals with particular interests of local alcohol industry. However, it was observed that when environments and alignments changed a few years later, support for the policy diminished and the programme dissipated.

In research from Sweden, Geidne and colleagues (2013)⁵¹ examined an alcohol policy project in football clubs. The authors found that a **mix of community level factors**, football club characteristics, organisational capacity, and training and technical assistance factors influenced whether clubs implemented this initiative. For example, clubs' concern with social responsibility and engagement enhanced their participation, and meetings organised where clubs could share experiences were perceived as valuable.

In the United States, Jones-Webb and colleagues (2014)⁵² undertook a case study of US cities that adopted policies to restrict high-alcohol malt liquor sales. The authors observed that at every stage of the alcohol policy process, the external social, political, and economic context can influence policy actors and actions. In addition, it was observed that **the following activities are important for alcohol policy implementation**: building public awareness and educating stakeholders; monitoring and enforcing **compliance**; **evaluating process and outcomes**; and institutionalising the policy.

Also in the United States, Nelson and colleagues (2015)⁵³ conducted a longitudinal analysis of alcohol policy implementation in all 50 states (and the District of Columbia) between 1999-2011. They sought to explore whether the feasibility and acceptability of different alcohol policies to the public and policymakers would be a barrier to the implementation of these policies. The authors found that, indeed, **alcohol policies which were more “politically palatable” (e.g. policies targeting youth or drink driving) increased** during this time period. In contrast, policies which were deemed to be the most effective for reducing adult alcohol consumption based on existing evidence (e.g. alcohol taxes, price restrictions, or outlet density restrictions), were less likely to be implemented during this time period.

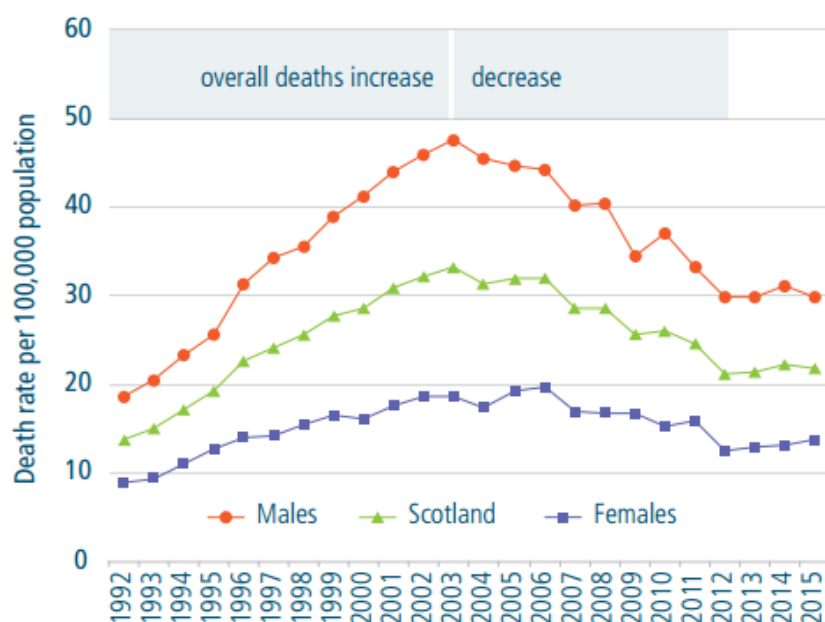
Alcohol Policy Implementation in Scotland

The issue of alcohol misuse in Scotland has been recognised across political parties. In June 2015 a Parliamentary debate heard a motion to both recognise the progress made thus far on tackling alcohol misuse and to push for further preventative action and additional measures to reduce the harmful use of alcohol.⁵⁴ In this debate, Members of the Scottish Parliament consistently noted the continued individual and societal costs of alcohol-related harms in Scotland and the health inequalities that result.⁵⁴

Key Facts About Alcohol-Related Harm in Scotland

- Relatively high consumption in Scotland has led to a correspondingly high rate of alcohol-related harms and costs⁵⁵
- Monitoring trends in alcohol consumption shows that population consumption has declined in recent years, although that decline may now be flattening⁵⁶
- In 2015/16 almost 35,000 people were admitted as inpatients to hospital for an alcohol-related reason, which was similar to the previous year⁵⁷
- In 2015, there were 1,150 alcohol-related deaths, similar to the previous year⁵⁷
- There continues to be an inequality gap for alcohol-related admissions between those living in the most and least deprived parts of Scotland⁵⁷

Alcohol-related deaths in Scotland, by sex, 1992 to 2015



In 2015 in Scotland alcohol caused an average 22 deaths per week



http://www.healthscotland.scot/media/1458/alcohol-related-harm-in-scotland-2016_english.pdf

Relevant Scottish Policy and Legislation

In 2009 the Scottish Government published [*Changing Scotland's Relationship with Alcohol: A Framework for Action*](#).⁵⁸ This policy provides the core of the overall Alcohol Strategy, and has therefore been a key source of guidance for alcohol policy implementation. A refresh of the *Framework for Action* is expected to be published by the Scottish Government in late 2017.

During policy **planning** of the *Framework for Action*, the Scottish Government published a **discussion paper** on their intended strategic approach, and their subsequent **consultation** received 472 responses.⁵⁹ This discussion paper, and the resulting policy, contained some guidance for how the policy would be implemented. For example, certain aspects of Scotland's Alcohol Strategy are intended to be implemented locally, including those related to service provision, education, and health promotion.⁵⁸ Examples include alcohol brief interventions and services for children and families. Other components of the strategy (e.g. reduction in the drink driving limit) have been implemented at national level.⁶⁰

In addition to the *Framework for Action*, three pieces of enacted legislation contribute to the overarching Strategy: the [Licensing \(Scotland\) Act \(2005\)](#), the [Alcohol etc. \(Scotland\) Act \(2010\)](#), and the [Air Weapons and Licensing \(Scotland\) Act 2015](#) (Box 1). A fourth component, the [Alcohol Minimum Pricing Act \(2012\)](#) is being challenged in the courts and has not yet been implemented.

Implemented Components of Scotland's Alcohol Strategy

[Licensing Act \(Scotland\) 2005](#)

Contains five licensing objectives, including 'protecting and improving public health' (this public health objective distinguishes Scotland from the UK and other countries globally ⁶¹)

[Changing Scotland's Relationship with Alcohol: A Framework for Action \(2009\)](#)

- Takes a 'whole-population' with targeting approach
- Four action areas:
 1. Reduced consumption
 2. Supporting families and communities
 3. Positive attitudes and positive choices
 4. Improved support and treatment

[Alcohol etc. \(Scotland\) Act 2010](#)

Makes provision for regulating sale of alcohol and licensing of premises.

[Air Weapons and Licensing \(Scotland\) Act 2015](#)

Amends legislation regarding alcohol licensing.

Stakeholders and Infrastructure

[Human resources](#) and [commitment](#) for alcohol policy implementation in Scotland comes from a range of national and local individuals, organisations, and institutions.

National stakeholders in alcohol policy and legislation include the Scottish Government, responsible for developing and delivering alcohol policy, and the Scottish Parliament, responsible for scrutinising policy.

At local level, bodies such as Local Authorities, Community Planning Partnerships (CPPs), and Health and Social Care Partnerships are relevant to the Strategy's implementation, and each have their own [organisational cultures](#). Local Authorities are responsible for providing services such as education, social care, and cultural services to their constituency. ⁶² They are governed by a local Council which runs autonomously from

central government.⁶² Local Authorities are represented nationally by the Convention of Scottish Local Authorities (COSLA) and the Scottish Local Government Partnership (SLGP), which lobby the Scottish Government on their behalf.

The [Local Government in Scotland Act 2003](#) established the statutory framework for Community Planning. The Act established 32 Community Planning Partnerships (CPPs), which service the same area as their respective Local Authorities, and are intended to ensure that local services are delivered in partnership between service providers. In addition to CPPs, the [Public Bodies \(Joint Working\) \(Scotland\) Act 2014](#) established a mandate for local authorities and Health Boards to integrate their health and social care services (also see [SPICe briefing on this topic](#)). This included a requirement to pursue either an Integrated Joint Board (IJB) (Body Corporate) Model or a Lead Agency Model of integration. Only [Highland Partnership](#) has used the lead agency model, which requires the NHS board and local authority to establish a 'joint monitoring committee'.⁶³ IJBs have been delegated a variety of local functions, including health and social care service delivery – a function relevant to alcohol-related services.

Within this local governance structure, the delivery of local alcohol-related policy and services is the responsibility of Scotland's [Alcohol and Drug Partnerships](#) (ADPs).⁶⁴ Partners on ADPs include, but are not limited to, representatives from health and social care, criminal justice, education, and the third sector.

Guidance for how ADPs are intended to support alcohol policy implementation is contained in documents such as [The Quality Principles \(2014\)](#) and [Updated Guidance for Alcohol & Drug Partnerships \(ADPs\) on Planning & Reporting Arrangements \(2015\)](#).

ADPs and their local partners are expected to commission evidence-based and recovery-oriented treatment and support services for their population. They are **accountable** for reporting back to their local area's CPP and Integration Authority, as well as to the Scottish Government on Ministerial priorities and targets. Core outcomes that ADPs are **accountable** for include those related to improving health, enhancing community safety, and supporting health-promoting local environments. A list of ADP core outcomes and core indicators can be [found here](#).

Financial resources for ADPs are provided by the Scottish Government, via their respective local Health Boards. There was concern in the 2016/17 financial year about the implementation of [22.25% budget cuts to Alcohol and Drug Partnerships](#), which was expected to be covered by local Health Board budgets.⁶⁵ The budget for ADPs is unchanged from 2016/17 levels for 2017/2018.^{66 67}

[Licensing Boards](#) are independent regulatory bodies located in each local authority area, and are responsible for local decision-making about alcohol licensing. The relevant legislation for alcohol licensing and the actions of Licensing Boards is the [Licensing \(Scotland\) Act 2005](#).

There are a range of other stakeholders involved in alcohol policy in Scotland. These include organisations such as the British Medical Association Scotland, Alcohol Focus Scotland, and the Scottish Health Action on Alcohol Problems (SHAAP), as well as the alcohol industry.

Alcohol Policy Stakeholders in Scotland

Scottish National Level	<div data-bbox="687 259 979 479"> Scottish Parliament Health and Sport Parliamentary Committee </div> <div data-bbox="1038 259 1345 479"> Scottish Government Alcohol Policy Team Substance Misuse Team </div>
Local Area Level	<div data-bbox="687 566 979 622"> Local Authorities </div> <div data-bbox="1038 566 1331 663"> Community Planning Partnerships </div> <div data-bbox="687 663 979 931"> Health and Social Care Integration Partnerships (and Integration Joint Boards or Integrated Joint Monitoring Committee) </div> <div data-bbox="1038 685 1331 848"> Alcohol and Drug Partnerships (and member organisations) </div> <div data-bbox="1038 875 1331 931"> Licensing Boards </div>
Other Stakeholders	<div data-bbox="687 1014 987 1312"> Third Sector and Nationally Commissioned Bodies e.g. Alcohol Focus Scotland; Scottish Health Action on Alcohol Problems </div> <div data-bbox="1050 1014 1345 1178"> Private Sector e.g. alcohol producers and retailers </div>

Links to Other Policy

Alcohol-related harm is linked with a wide range of societal issues, and is therefore linked to other Scottish policies and legislation. This includes, for example, health policies and reports such as the Scottish Government's national drugs strategy, *The Road to Recovery (2008)* and *Equally Well (2008, 2010)*, the report of the Ministerial Task Force on Health Inequalities. As broader public policy examples, the *National Performance Framework* indicates important linkages that can and should be made across Scotland's public service sector in order to achieve identified goals for Scotland⁶⁸, including health and economic considerations. Other examples include, but are not limited to, the *Commission on the Future Delivery of Public Services (2011)* ("Christie Commission"), *The Early Years Framework (2009)*, *Justice in Scotland: Vision and Priorities (2017)* and *The Strategy for Justice in Scotland (2012)*.

Evaluating Alcohol Policy in Scotland

Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS)

In 2010 the Scottish Government tasked NHS Health Scotland with **monitoring and evaluating** Scotland's alcohol strategy in order to attain evidence on the strategy's outcomes. Along with the NHS National Services Scotland Information Services Division (ISD), NHS Health Scotland established a taskforce called Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) to carry out this work. The MESAS work portfolio was composed of eight separate studies, which considered how the strategy might be implemented differently to improve effectiveness, how people and businesses were affected, and to what extent the alcohol strategy contributed to a reduction in alcohol-related harm. MESAS published multiple annual reports describing the progress and results of these studies, and a **final report** in March 2016. In this report, MESAS recommends that: *"Effort is made to improve implementation of existing components of the strategy, particularly those with the potential to reduce the availability of alcohol and to incorporate the learning on implementation facilitators when developing new interventions."*(p.7) ⁵⁶ Certain monitoring work by MESAS is ongoing and their **2017 report can be found [here](#)** .

Alcohol Policy Implementation Research

Scottish Research

In a study that was part of the MESAS portfolio of work, MacGregor et al. (2013) ³⁴ analysed the implementation of the Licensing (Scotland) Act 2005. Their study reported that overall, the Licensing Act can be seen to have had a positive impact. As a specific example, the creation of Licensing Standards Officers (LSOs) has been perceived as successful in terms of how they have contributed to improved relations between Licensing Boards and licensed premises.

The study does, however, note challenges and facilitators for effectively implementing licensing legislation in Scotland.

Challenges include:

- A lack of updated national guidance for implementing legislation;
- Reported problems in interpreting the legislation; and
- National and local data were not being collected/collated consistently or in a manner which allowed meaningful comparison.

Regarding the public health objective of the Licensing Act specifically, implementation has been hampered by: the lack of an adequate definition; lack of understanding about what data sources should be used or how the objective would be monitored; the 'population-based approach' of the objective was difficult to relate to individual alcohol outlets; and concern that legal decisions would be overturned by Sheriffs and thus decisions were made cautiously.

Facilitators of implementing licensing legislation included:

- Where training was required, it was helpful for it to be both mandatory and monitored; and
- Establishment of LSOs led to the perception that trade were now more likely to comply with the Act, with fewer reviews being sent to Licensing Board level.

The study also makes a number of recommendations for more effective implementation of licensing (an annotated list is provided here, please find the complete list in [MacGregor et al. 2013, p xii-xiii](#))³⁴ :

- More guidance and support be given nationally in relation to:
 - the public health objective
 - capacity and over-provision
 - the role and function of Licensing Forums
 - Any new, relevant legislation that has implemented
- Consideration given to role of Licensing Standards Officers, with respect to their number, training, legal support, and capacity to collect and collate data;
- Require Licensing Boards to give further consideration to the public health objective, carry out assessments of capacity and overprovision, share best practices with other Boards, and improve data collection;
- Ensure licensed trade continues to undergo mandatory and ongoing training, maintains good links with LSOs, and consider measures to address public harms that result from alcohol misuse.
- Consistent collection and collating by Boards and LSOs of agreed data.

In another study from the MESAS portfolio, Parkes, Atherton, Evans et al. (2011)⁶⁹ specifically evaluated the process of implementing ABIs, with a focus on their mainstreaming into primary care. The authors found that the original HEAT target (now called a [Local Delivery Plan \[LDP\] Standard](#)), which sought to embed ABIs into regular NHS practice, was achieved in March 2011, and the authors' assessment is that the implementation of this component of Scotland's alcohol strategy was carried out in line with government guidance.

However, one of the authors' most significant findings was that the practical implementation of ABIs was hugely varied across Scotland.⁶⁹ They particularly highlight the different payment structures for ABIs in primary care, and the ways that Health Boards contextualised the ABI programme to fit their local needs. In addition, geographical gaps in implementation remained at the time of the report's publication, particularly in rural and remote areas. This study observed that there was buy-in among healthcare staff about the value of ABIs and the use of resources to deliver them. The authors also found that it was very important for universal systems and standards for recording to be developed for the purposes of data collection and monitoring.

It was noted that a one-year extension of specific funding and infrastructure support to continue the ABI programme was a welcome source of support, however the authors suggested that these supports will likely need to be maintained longer if ABIs are to be fully implemented into regular practice.⁶⁹

In research in the broader academic literature, Fitzgerald and colleagues (2017)⁶¹ examined how the public health objective has been enacted within the context of alcohol licensing in Scotland. These researchers specifically explored how public health practitioners (including representatives from the NHS, Alcohol and Drug Partnerships, and national or third sector organisations) navigated this system since the objective was introduced as part of the [Licensing \(Scotland\) Act 2005](#).

This study found that a challenge public health practitioners faced in attempting to support the enactment of the public health objective was the perception that although they were working from a 'whole-population approach', that this approach had not always been adopted by other licensing stakeholders. For example, interviewees in this study perceived widespread disagreement among licensing stakeholders about whether current alcohol consumption and related harms pose significant problems to Scottish society. In addition, interviewees suggested that there was a lack of consensus about whether "addressing public health was a legitimate role of licensing" (p.7). On a related note, it was reported that Licensing Boards tended to prioritise economic considerations over public health ones.⁶¹

Interviewees in this study also reported that health evidence they provided to licensing stakeholders was often not persuasive to these audiences. For example, they reported that statistical data was not perceived as trustworthy by certain Licensing Board members. However, it was noted that there may be an important role for the public in providing anecdotal and experiential evidence related to public health to communicate to actors across the licensing system.⁶¹

Finally, it was reported that building positive relationships between public health practitioners and licensing stakeholders would help with progress towards enacting the public health objective.⁶¹

In another study by Fitzgerald and colleagues (2015)⁷⁰, the authors examine the implementation of ABIs. This study explored experiences of implementing ABIs in antenatal, accident, and emergency health care settings, and found that five strategies were helpful for implementing ABIs in any setting (quoted from Fitzgerald et al 2015):

1. Having a high-profile target for the number of ABIs delivered in a specific time period with clarity about whose responsibility it was to implement the target;
2. Gaining support from senior staff from the start;
3. Adapting the intervention, using a pragmatic, collaborative approach, to fit with current practice;
4. Establishing practical and robust recording, monitoring and reporting systems for intervention delivery, prior to widespread implementation; and
5. Establishing close working relationships with frontline staff including flexible approaches to training and readily available support.

UK Research

Two research papers from elsewhere in the UK discussed the issue of alcohol policy implementation, and their findings are relevant for consideration.

Martineau and colleagues (2013)⁷¹, writing about alcohol licensing from a public health perspective, argue that the lack of a 'public health objective' in England and Wales constrains local actors' ability to address alcohol-related health harms. The researchers note that, despite this, public health advocates can still seek to influence licensing decisions, for example by providing evidence that links alcohol outlet density to drinking behaviour (and how this relates to issues like crime and anti-social behaviour). This work can be supported by national level actors through the development of resources such as evidence reviews, evaluation tools, and case studies of best practice.⁷¹ Although Scotland does have a public health objective for licensing, evidence suggests it is not currently being implemented sufficiently,⁶¹ therefore these types of supports would likely still be useful in the Scottish context.

In another UK-based study, Thom and colleagues (2011)³⁷ provide an overview of partnership working in England with respect to alcohol policy implementation. This study found a clear shift to using partnership approaches to delivering alcohol policy, which was perceived as both positive and necessary by the study participants. The authors also found that 'buy-in' and commitment from those in leadership positions, as well as alcohol 'champions', were key factors in the success of these partnerships to conduct alcohol policy implementation. A number of challenges were noted however, including (annotated from Thom et al. 2011, p.60-61):

- the need to manage cuts in resources, often in the face of increasing demands and existing tensions around prioritising aims and targeting resources;
- Difficulties establishing shared priorities and goals among partners, which was influenced by the level of trust between partners, and the quality of communication and information sharing;
- The need for commitments from 'top people' to ensuring alcohol was part of local planning agendas;
- The need to change professional behaviour to move away from 'siloe'd' working;
- Managing the size and complexity of the partnerships, and their relationships to the rest of the local system; and
- The need to respond to local needs, especially in rural areas.

Summary Points

- Effective implementation is critical to the success of health policies. If policies are not implemented, then policy goals and outcomes cannot be achieved
- Planning for effective implementation is therefore an important consideration during policy development and scrutiny
- A number of facilitators exist which can enhance the policy implementation process, and if absent, policy implementation can face critical challenges. These include, but are not limited to:
 - Considerable commitment and leadership
 - Meaningful involvement of local policy stakeholders, members of the target population, and other stakeholders in policy planning and development
 - Adequate, sustainable resources
 - Consideration of factors such as competing strategic/governmental priorities (e.g. public health versus economic growth) to mitigate unanticipated consequences
 - Appropriate accountability mechanisms
 - Ongoing monitoring and evaluation of policy implementation, and the application of this learning

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APPENDIX 4 – PRISMA Checklist

Appendix 4: PRISMA 2009 Checklist

Use of the PRISMA checklist assists authors to ensure they transparently and completely report their systematic review (Liberati et al., 2009).

This checklist (Moher et al., 2009) and its' explanation document (Liberati et al., 2009) helped guide the development of the systematic review in Chapter 3. Note, however, that elements of the checklist needed to be interpreted in light of my systematic review's focus on public health policy (as opposed to, for example, a clinical or behavioural intervention). This type of modification is states as acceptable to the PRISMA authors, who note, "some modifications of the checklist items or flow diagram will be necessary in particular circumstances." (Moher et al., 2009, pg 5).

Section/topic	#	Checklist item	Reported in Section #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	Chapter title identifies this review as a systematic review.
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	Systematic review is contained within a broader doctoral thesis, so summary is provided within thesis abstract. Systematic review registration number provided in Section 3.2.
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	Provided in Chapter 1 of thesis and Section 3.1 of review chapter
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	Explicit questions presented in Section 3.1, however PICOS relevant to review aim.

METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	Registered with PROSPERO in March 2019, number CRD42019124477.
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	Inclusion and exclusion criteria provided in Section 3.2.2.
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	Provided in Section 3.2.1 and 3.2.3.
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Provided in Section 3.2.1.
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	Provided in Section 3.2.3.
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	Provided in Section 3.2.4, and limitations to this approach (given review undertaken by a sole researcher) are provided in Section 3.4.5.
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	Provided in Section 3.2.4.
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	Approach to appraising included studies for quality provided in Section 3.2.4.
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	This approach does not apply to this review, as results were reported for a series of categories in a narrative way (see Section 3.2 for Results, in

			particular Section 3.3.2)
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	Methods of handling the data are provided in Section 3.2.4. 'Measures of consistency' were not applicable.
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	While a quality assessment of each study was undertaken, the 'risk of bias' was not applicable to this review, because the majority of studies were qualitative and the researcher brought an interpretive lens to her analysis of them. This lens considers research to be inherently contextual.
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	Not applicable.
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	Provided in Section 3.3.1.
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	Provided in Section 3.3.1, particularly Tables 3.2 and 3.3.
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	Approach to appraising included studies for quality provided in Section 3.2.4. This review was concerned with how implementation occurred, excluding studies which focus on measuring outcomes, therefore no outcome level assessments were conducted.
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally	Key findings of each included study provided in Table 3.3.

		with a forest plot.	
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	Results of data synthesis were reported under category headings in Section 3.3.2, in a narrative manner.
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	See answer to Item 15.
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	Not applicable.
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	Provided in Section 3.4.
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	Provided in Section 3.4.5.
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	Provided in Section 3.4 and 3.5
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	Funding for the overarching PhD research has been reported in the front matter to the thesis.

APPENDIX 5 – Round 1 and 2 Search Strings

Systematic Review, Round 1 and 2 Search Strings in Full

Round 1 Search Strings

Database	Search String
IBSS (ProQuest)	ab(alcohol) AND (policy OR policies OR legislat* OR regulat*) AND (implementation OR governance) <i>Above is limited to English, and scholarly journal articles.</i>
Social Science Database (ProQuest)	ab(alcohol) AND (policy OR policies OR legislat* OR regulat*) AND (implementation OR governance) <i>Above is limited to English, and scholarly journal articles.</i>
PsycInfo (Ovid)	(alcohol.ti. and (policy or policies or regulat* or legislat*).af. and (implementation or governance).ab.) not (medicine or oncology or pharmacolog* or biotechnology* or forensic* or transplant* or diagnostic or genetic* or dental or dentist* or infection or agricultur* or neurolog* or surgery or pediatric* or pharmaceut* or laboratory).ab. not (medicine or oncology or cancer or pharmacology or biotechnology or forensic or transplant* or diagnostic or genetic* or dental or dentist* or infection or agricultur* or neurolog* or surgery or pediatric* or pharmaceut* or laboratory).ti. <i>Above is limited to research with humans and English language</i>
PubMed	(((((alcohol[Title/Abstract]) AND (policy[Title/Abstract] OR policies[Title/Abstract] OR regulat*[Title/Abstract] OR legislat*[Title/Abstract]))) AND (implementation OR governance)) AND Humans[Mesh])) NOT (medicine[Title] OR oncology[Title] OR cancer[Title] OR pharmacology[Title] OR biotechnology[Title] OR forensic[Title] OR transplant*[Title] OR diagnostic[Title] OR genetic*[Title] OR dental[Title] OR dentist*[Title] OR infection[Title] OR agricultur*[Title] OR neurolog*[Title] OR surgery[Title] OR pediatric*[Title] OR pharmaceut*[Title] OR laboratory[Title]))
ScienceDirect	Title, abstract, keywords: alcohol AND (policy OR policies OR legislation OR regulation OR regulations) AND (implementation OR governance)
Scopus	(TITLE- ABS- KEY (alcohol AND (policy OR policies OR regulat* OR legislat*) AND (implementation OR governance)) AND NOT TITLE-ABS- KEY (pharmaceut* OR medicine OR oncology OR cancer OR phar maco* OR biotechnology OR forensic OR transplant* OR diagnostic OR genetic* OR dental OR dentist* OR infection OR agricultur* O R neurolog* OR surgery OR pediatric* OR laboratory) AND NOT TITLE-ABS- KEY (hiv OR diabetes OR methanol OR ethanol OR "in the workplace" OR cocaine OR cannabis OR marijuana OR opioid OR naloxone OR naltrexone OR "sport clubs" OR "sports clubs" OR poison* OR cigarette* OR e-cigarette* OR "electronic cigarette*" OR butanol)) AND (LIMIT-TO (LANGUAGE, "English"))
Web of Science	(TS=(alcohol) AND TS=(policy OR legislat* OR regulat*) AND TS=(implementation OR governance)) AND LANGUAGE: (English) Indexes=SSCI, A&HCI Timespan=All years

(* indicates a truncation of the word to include all forms of that word)

Round 2 Search Strings

Database	Search String
IBSS (ProQuest)	ab(alcohol) AND ab(availability OR licens* OR marketing OR price OR affordability) AND (implementing OR implementation) AND policy <i>Results limited to scholarly journals and English language</i>
Social Science Database (ProQuest)	ab(alcohol) AND ab(availability OR licens* OR marketing OR price OR affordability) AND (implementing OR implementation) AND policy <i>Results limited to scholarly journals and English language</i>
PsycInfo (Ovid)	(alcohol.ti. and (availability or licens* or marketing or price or affordability).af. and (implementing or implementation).ab.) not (medicine or oncology or pharmacolog* or biotechnology* or forensic* or transplant* or diagnostic or genetic* or dental or dentist* or infection or agricultur* or neurolog* or surgery or pediatric* or pharmaceut* or laboratory).ab. not (medicine or oncology or cancer or pharmacology or biotechnology or forensic or transplant* or diagnostic or genetic* or dental or dentist* or infection or agricultur* or neurolog* or surgery or pediatric* or pharmaceut* or laboratory).ti.
PubMed	((((((alcohol[Title/Abstract]) AND (availability[Title/Abstract] OR licens*[Title/Abstract] OR marketing[Title/Abstract] OR price[Title/Abstract] OR affordability[Title/Abstract]) AND (implementing[All Fields] OR implementation[All Fields]) NOT (medicine[Title] OR oncology[Title] OR cancer[Title] OR pharmacology[Title] OR biotechnology[Title] OR forensic[Title] OR transplant*[Title] OR diagnostic[Title] OR genetic*[Title] OR dental[Title] OR dentist*[Title] OR infection[Title] OR agricultur*[Title] OR neurolog*[Title] OR surgery[Title] OR pediatric*[Title] OR pharmaceut*[Title] OR laboratory[Title]))) AND Humans[Mesh])))
ScienceDirect	Advanced search: Title, abstract or keywords: alcohol AND (implementing OR implementation) AND (availability OR licensing OR licensed OR marketing OR price OR affordability) Title: NOT (medicine OR oncology OR cancer OR pharmacology OR biotechnology OR forensic OR transplant OR diagnostic OR genetic OR dental OR dentist OR infection OR agricultur OR neurologic OR surgery OR pediatric OR pharmaceut OR laboratory)
Scopus	(TITLE-ABS-KEY (alcohol AND (implementing OR implementation) AND policy) AND TITLE-ABS-KEY (availability OR licens* OR marketing OR price OR affordability)) AND (LIMIT-TO (LANGUAGE , "English"))
Web of Science	(TI=(alcohol) AND TS=(availability or licens* or marketing or price or affordability) AND TS=(implementing or implementation))AND LANGUAGE: (English) Indexes=SSCI, A&HCI Timespan=All years

APPENDIX 6 – Quality Assessment of Studies in Systematic Review

Quality Assessment of Studies Included in Systematic Review, using Hawker et al (2002)										
Author	Abstract and title	Introduction and aims	Method and data	Sampling	Data Analysis	Ethics and bias	Results	Transferability or generalizability	Implications and usefulness	Score:
Berends et al	Good (4)	Fair (3)	Fair (3)	Poor (2)	Fair (3)	Poor (2)	Fair (3)	Fair (3)	Good (4)	27 (Intermediate)
Casswell et al	Fair (3)	Poor (2)	Poor (2)	Fair (3)	Poor (2)	Poor (2)	Good (4)	Good (4)	Good (4)	26 (Intermediate)
Chalmers et al	Good (4)	Fair (3)	Good (4)	Good (4)	Very poor (1)	Poor (2)	Good (4)	Poor (2)	Good (4)	26 (Intermediate)
Fitzgerald et al (2015)	Good (4)	Good (4)	Good (4)	Fair (3)	Good (4)	Good (4) - discuss ethics approval;	Good (4)	Fair (3)	Fair (3) - missing recommendations for future research	33 (High quality)
Fitzgerald et al (2017)	Good (4)	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3) - didn't reflect on bias	Good (4)	Fair (3)	Good (4)	34 (High)
Fitzgerald et al (2018)	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Good (4)	Good (4)	Good (4)	Good (4)	35 (High quality)
Foster et al (2007)	Good (4)	Good (4)	Fair (3)	Good (4)	Fair (3)	Very poor (1) - no mention	Fair (3)	Fair (3)	Good (4)	29 (Medium quality)
Foster (2016)	Good (4)	Good (4)	Good (4)	Poor (2)	Poor (2)	Good (4)	Good (4)	Good (4)	Good (4)	32 (High quality)
Grace et al	Fair (3)	Fair (3)	Fair (3)	Good (4)	Fair (3)	Very poor (1)	Good (4)	Poor (2)	Good (4)	27 (Medium Quality)
Hadfield et al	Fair (3)	Good (4)	Fair (3)	Good (4) (in Appendix)	Very Poor (1)	Very Poor (1) Funded in part by organisation funded by alcohol industry, only brief nod to COI statement Fair- Study 2 described how tried to address observer bias in data collection Average: Poor (2)	Fair (3) - did not provide example quotations from data	Fair (3)	Fair (3) (missing contributing something new/different - given literature demonstrating CSR is not effective in regulating industry)	26 (Medium Quality)
Hadfield et al 2011	Fair (3)	Fair (3)	Fair (3)	Poor (2)	Very Poor (1)	Poor (2)	Fair (3)	Fair (3)	Poor (2) - doesn't provide areas for future research or implications for policy/practice	22 (low quality)
Haggard et al	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Good (4)	Good (4)	Good (4)	Fair (3) (missing recommendations for future research)	33 (High quality)
Hawkins et al	Fair (3)	Good (4)	Good (4)	Fair (3)	Poor (2)	Very Poor (1)	Good (4)	Good (4)	Fair (3) (missing recommendations for future research)	26 (Intermediate)
Herring et al	Good (4)	Fair (3)	Fair (3)	Fair (3)	Poor (2)	Very poor (1)	Good (4)	Fair (3)	Good (4)	27 (Intermediate)
Humphreys et al	Fair (3)	Good (4)	Fair (3)	Poor (2)	Good (4)	Very poor (1)	Good (4)	Fair (3)	Good (4)	28 (Intermediate)
Lloyd et al	Fair (3)	Good (4)	Good (4)	Poor (2)	Poor (2)	Very poor (1)	Good (4)	Fair (3)	Fair (3) (missing recommendations for future research)	26 (Intermediate)
MacGregor et al	Good (4)	Good (4)	Good (4)	Fair (3)	Poor (2)	Very poor (1)	Good (4)	Good (4)	Good (4)	30 (High quality)
Martineau et al	Good (4)	Fair (3)	Fair (3)	Poor (2)	Poor (2)	Very poor (1)	Good (4)	Fair (3)	Fair (3) (missing recommendations for future research)	25 (Intermediate)
Mooney et al	Good (4)	Fair (3)	Good (4)	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Good (4)	34 (High)
Muhunthan et al	Good (4)	Fair (3)	Fair (3)	Very poor (1)	Good (4)	Ethics N/A - secondary analysis of legal cases Very poor (1) - no mention of bias in terms of interpretation	Good (4)	Fair (3)	Fair (3)	26 (Intermediate)
Parkes et al (2011)	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Fair (3) - didn't reflect on bias, but noted where ethics sourced from	Good (4)	Fair (3)	Good (4)	32 (High quality)
Randerson et al (2018)	Good (4)	Good (4)	Good (4)	Fair (3)	Poor (2)	Very poor (1)	Good (4)	Fair (3)	Fair (3) (missing recommendations for future research)	28 (Intermediate)
Rieckmann et al	Good (4)	Poor (2)	Good (4)	Good (4)	Good (4)	Poor (2) - while state the project was approved, do not justify why informed consent was not required for in-depth interviews	Fair (3)	Fair (3)	Good (4)	30 (High quality)
Rod et al	Good (4)	Fair (3)	Good (4)	Fair (3)	Fair (3)	Very poor (1)	Good (4)	Fair (3)	Fair (3) missing recommendations for future research	28 (Intermediate)
Thom et al (2013) Eval of AIP	Fair (3)	Good (4)	Fair (3)	Fair (3)	Fair (3)	Fair(3) some reflection on bias within results and stated ethical approval source	Fair (3) - would have liked more example quotations from data	Good (4)	Good (4)	29 (intermediate quality)
Thom et al	Good (4)	Good (4)	Good (4)	Fair (3)	Very poor (1)	Very poor (1)	Good (4)	Fair (3)	Good (4)	28 (Medium Quality)
Thompson et al	Good (4)	Fair (3)	Good (4)	Fair (3)	Fair (3)	Ethics N/A - secondary analysis of legal cases Poor (2) - minimal discussion of how results may be limited /biased	Good (4)	Good (4)	Good (4)	31 (High quality)
Toner et al	Fair (3)	Fair (3)	Fair (3)	Poor (2)	Fair (3)	Very poor (1)	Fair (3)	Fair (3) (didn't receive Fair or higher under sampling, but this is perceived as not problematic given methods of study, in terms of awarding 'Fair' under transferability)	Poor (2) - only provides new insight into evidence in alcohol policy; doesn't provide areas for future research or implications for policy	25 (Medium Quality)
Zahnow et al (2018)	Fair (3)	Good (4)	Fair (3)	Fair (3)	Good (4)	Fair (3)	Good (4)	Fair (3)	Good (4)	31 (High quality)

APPENDIX 7 – PhD Research Statement

The use of evidence in local policy implementation: a case study of Scotland's Alcohol Strategy

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Summary

This PhD project is examining how Scotland's Local Authority areas have implemented Scotland's Alcohol Strategy, and how various types of information have been used in this process. The Alcohol Strategy was developed by the Scottish Government with the aim of reducing alcohol-related harm experienced by individuals and communities¹. This PhD project aims to generate knowledge on the case of implementing national alcohol policy in Scotland, with a view to inform health policy implementation and the use of evidence in this endeavour. The implications of this knowledge for the development and implementation of future national health policies will be identified and elaborated in terms of knowledge exchange activities, such as in presentations to stakeholders.

Value of This Work

In examining the implementation of Scotland's Alcohol Strategy, this project will develop a deeper understanding of multi-agency and multilevel policy efforts to tackle alcohol-related harms and health and social inequalities.

This PhD project seeks to work with Local Authority areas that are partnering with the What Works Scotland initiative. The project will examine what has worked or not worked during implementation of the Alcohol Strategy in these Local Authority areas, which will offer a deeper understanding of policy implementation in communities with varying characteristics. For Scotland, this creates a timely opportunity for better integration of local-level considerations into the national integrated health and social care regulatory framework. By better informing policymakers of the complex conditions for high-quality health policy, Scotland can attain more contextually-sensitive, effective planning and service delivery.

Main Aims

This project aims to inform future health and social policy development, refinement and delivery by generating knowledge on: (i) how local authority areas adapt and implement national preventative health policies; (ii) how evidence is used by local implementers during the planning and process of implementation; and (iii) implications for the future development and implementation of national health policies that can be effectively implemented at local level. This knowledge will be generated with respect to Scotland's Alcohol Strategy, however it is anticipated that the broader learning could be applied to the development and implementation of other national preventative policies aimed at reducing health and social inequalities.

¹ Scottish Government, 2009. Changing Scotland's relationship with alcohol: a framework for action. Scottish Government, Edinburgh.

Research Objectives

1. Understand how local implementers in Scotland's Local Authorities have undertaken the process of implementing alcohol policy in their local contexts.
2. Understand how local implementers in Scotland's Local Authorities have used information and evidence to make decisions during the planning and process implementing alcohol policy.
3. Discuss/explore the implications of these findings (Objective 1 & 2) for the implementation of national preventative health policies, and communicate these to both national and local stakeholders.

Research Strategy

Specific details of the research methods will be driven by local context and opportunities, however this PhD project is following a qualitative, embedded case study strategy. The overarching case of interest is the process of policy implementation of Scotland's Alcohol Strategy. The embedded sub-units of analysis are three selected Local Authority areas in Scotland. Data collection will be centred on three main activities:

1. In-depth interviews with local government actors responsible for implementing alcohol policy. This may include representatives from Alcohol and Drug Partnerships (ADPs), CPPs, Health Boards, Licensing Boards and relevant third sector organizations. (Commencing December 2015)
2. Interviews with national-level stakeholders who were centrally involved in the policy process at national level, to examine the implications of the knowledge emerging from local level and needs for future development of national preventative health policies.
3. Analysis of key documents such as policy documents will be conducted throughout the project.

Analysis of the collected data will be conducted qualitatively, and the results of the research will be written up for inclusion in the researcher's PhD Thesis. Ethical approval for this research has been granted by the University of Edinburgh.

Knowledge Exchange

The researcher has initiated knowledge exchange activities through discussions with key stakeholders in academia and the public and third sectors, in order to better understand the unique contribution to knowledge this research can make. Throughout the project, the researcher is seeking opportunities to discuss this research with institutions in the public, third and private sectors, and to explore knowledge exchange opportunities with national and local government. At key stages of the project the results of research findings will be written up for scientific publication and presentation at conferences and seminars (with links shared with ADPs and Scottish Government), and may lead onto further research studies.

Expected Outcomes

Expected outcomes of the project are: i) a critical understanding of how national preventative health policies are adapted and implemented at sub-national level; ii) synthesis of how evidence is used during the planning and process of health policy implementation at local level; and iii) critical discussion of the implications of this knowledge for more effective national health and social policy development that takes into account the complex factors that affect policy implementation. A series of recommendations for national and local policymakers will be developed to facilitate more informed, equitable health policymaking that can be effectively implemented at local level.

APPENDIX 8 – Use of Cards

Use of Cards in Interviews to Explore Evidence Use

As discussed within the text, near the end of each interview I conducted a card exercise. As also noted, the cards drew directly from existing literature: on each card was a known barrier to using evidence in policy and practice (Oliver et al. 2014), and interviewees were asked whether any of the barriers resonated with their own experiences, and about whether and how they had tried to overcome those barriers.

The cards included:

- Accessibility of evidence
- “Actionability” of evidence
- Availability of evidence
- Credibility of evidence
- Financial resources
- “Gulf” between researchers and policymakers
- Limited time
- Presentation of evidence
- Staff capacity (to be aware of, gather, and interpret evidence)
- Timeliness of evidence

Photo of selected cards used to explore barriers to evidence use



Although this exercise introduced a more standardised approach to the interviews than the semi-structured format of other sections, the ways participants engaged with, and responded to, the cards suggested a range of interpretations of the cards' content. For example, some participants spoke about the cards as if they named barriers to carrying out their alcohol policy work generally, not necessarily as barriers to using evidence within that work. To try to mitigate this tendency, I began introducing this exercise with some version of the statement, “Now, I’m going to ask you to put your ‘evidence’ hat on again”. I would mime putting on a hat, asking the interviewee to adopt this frame of mind when interacting with the cards. This

approach had some success in getting interviewees to focus on these barriers in terms of evidence-use specifically.

One benefit of the cards was that they offered a structure that often kept the interviewee more focused on the topic during that period in the interview. For example, some people approached the exercise in a task-oriented manner - once an interviewee had reflected on the content of one card, they would remain focused on the 'task' and move on to another card, as opposed to transitioning into another topic or reflection (a tendency many interviewees showed when answering other, earlier questions). As another example, interviewees would physically touch and arrange each of the cards into groups based on those which resonated with their own experiences and those which did not. Having all the cards laid on the table at once, instead of revealing them one-by-one, seemed to facilitate interviewee engagement with the exercise. In order to capture the physical gestures, I took more detailed written notes during this exercise, to supplement the interview transcripts. I would also often adopt a 'confirmation strategy' (Crilly et al., 2006, p. 360) in which I would respond to interviewees' gestures and comments by verbally naming the card they were talking about. For example:

AW: ...do any of these [cards] resonate with you?

Interviewee: I suppose both of those.

AW: Okay staff capacity, credibility, availability okay, do you want to elaborate a little bit on that?

I perceived that this card exercise had two additional benefits, given that it came near the end of the interview. First, although interviewees may have seemed fatigued near the end of the interview, when I presented the exercise with colourful cards, interviewees often seemed to visually 'perk up', leaning forward in their seat and demonstrating renewed enthusiasm for the discussion. Second, the task-orientation of the interview was useful logistically. I was often conscious of having limited time remaining with my interviewee at this stage of the interview, and thus using an exercise to keep the discussion succinct and focused seemed to be advantageous.

APPENDIX 9 – List of Meetings Observed

List of meetings and events observed

Meeting/Event Observed ^a	In Attendance	Notes or Comments
National/Regional Level		
Scottish Parliament Plenary Session on Alcohol (2015)	Members of the Scottish Parliament	Discussion of Motion 13358 (in name of Shona Robinson) which recognised the progress of the Government's 2009 alcohol policy, and called for further preventative action to tackle alcohol use and asks for views on additional measures to help tackle alcohol use.
AFS Knowledge Exchange Event (2015)	Multiple ADP representatives	Good introduction to wide variety of concerns and priorities among Scottish ADPs.
AFS Knowledge Exchange Event (2016)	Multiple ADP representatives; Deborah Shipton (NHS Health Scotland)	Spoke with Deborah Shipton about my research.
AFS Glasgow Regional Licensing Event (2016)	Range of alcohol licensing stakeholders, including representatives from ADPs, Councils, Health and Social Care Partnerships, Licensing Clerks, an industry representative, and Licensing Board Members	Gained broad overview of successes and challenges in licensing in different Local Authority areas. Observed the way the participation of an industry representative in these discussions changed the discussion.
AFS Edinburgh Regional Licensing Event (2016)	Range of alcohol licensing stakeholders, including representatives from ADPs, Councils, Health and Social Care Partnerships, Licensing Clerks, and Licensing Board Members	Gained broad overview of successes and challenges in licensing in different Local Authority areas. Met a Licensing Board member who I then successfully approached for a formal interview.
University of Edinburgh Knowledge Exchange Lunch (2016)	Representatives of local public and third sector organisations	Observed discussion of how local organisations wish to engage with academia, including their perspectives on best practices for the production and use of evidence. Informed my thinking for how to incorporate the theme of evidence use into my research
Local Level		
LA1 Executive Committee Meeting (2016)	Members of LA1 Executive Committee	Was introduced by ADP Coordinator to the other members, and was able to give brief overview of my research.
LA1 Executive Committee Meeting (2016)	Members of LA1 Executive Committee	Was able to present emerging findings for feedback.

LA1 Licensing Forum Meeting (2016)	Members of LA1 Licensing Forum	Observed the priorities and concerns of the Licensing Forum, and was later able to follow up with the Convenor in an informal discussion, providing further context for my research in LA1.
LA1 Licensing Board Meeting (2016)	Members of the LA1 Licensing Board; Licensing Solicitors; Licensing Applicants	First time observing the licensing process in real time, including the discussions of Councillors while debating whether to grant or reject a licence application.
LA2 Strategic Management Team Meeting (2016)	Members of LA2 Strategic Management Team	Was introduced by ADP Coordinator to the other members, and was able to give brief overview of my research.
LA2 Strategic Management Team Meeting (2016)	Members of LA2 Strategic Management Team	Presented findings from research.
LA2 Learning Event (2016)	Members of LA2 Strategic Management Team People in recovery Local Councillors	Event highlighted the key priorities and guiding principles of this ADP's work, some notable achievements, and demonstrated the role people in recovery are playing in ADP's activities.
LA2 Licensing Board Meeting (2016)	Members of the LA2 Licensing Board Licensing Solicitors Licensing Applicants	Observed dynamics and decision-making of Local Councillors on the Licensing Board. Observed that nearly all licenses were granted despite being in an area with an 'overprovision statement'.
LA3 Strategic Management Team Meeting (2016)	Members of LA3 Strategic Management Team	Was introduced by ADP Coordinator to the other members, and was able to give brief overview of my research.
LA3 Strategic Management Team Meeting (2017)	Members of LA3 Strategic Management Team	Presented findings from research.
^a All meetings and events were attended in person except my observation of an online video recording of the Scottish Parliament Plenary Session on Alcohol (4/06/2015)		

APPENDIX 10 – Ethics Approval, Edinburgh University

WRIGHT Alex

From: BANCROFT Angus
Sent: 29 April 2015 13:52
To: HUNTER Lindsay; WRIGHT Alex; HELLOWELL Mark
Subject: Fwd: Alex Wright - ethics application
Attachments: Wright_Ethics Level_2-3_Form (1).doc; ATT00001.htm; Wright_Ethics_PhD Research Proposal (1).docx; ATT00002.htm

Thanks Mark. I have reviewed the form and Alex has successfully addressed all reasonable foreseeable ethical issues and may go ahead
all the best
Angus

Begin forwarded message:

From: HELLOWELL Mark <Mark.Hellowell@ed.ac.uk>
Subject: Alex Wright - ethics application
Date: 29 April 2015 10:54:48 CEST
To: BANCROFT Angus <Angus.Bancroft@ed.ac.uk>

Dear Angus,

Please find attached an ethics application regarding Alex Wright's PhD project. I believe Alex has spoken to you about this.

The application needs very urgent attention in that the student wishes to interview an individual that is at an advanced stage of terminal cancer. The interview is crucial to the project.

I'm putting this application in at level 2 - I hope it can be turned around very quickly - but could you advise?

Many thanks,

Mark

APPENDIX 11 – Local Area Ethics Approvals

WRIGHT Alex

From: [REDACTED]
Sent: 29 September 2015 11:56
To: WRIGHT Alex; Health & Social Care Research & Information
Subject: RE: Application for PhD Research Access

Just to confirm that I am happy for this to proceed.

Thanks

[REDACTED]

Alex – it might be worth just checking out the list of ADP members has it may need updating.

[REDACTED] | [REDACTED] manager

[REDACTED]

From: WRIGHT Alex [mailto:alex.wright@ed.ac.uk]
Sent: 25 September 2015 14:27
To: Health & Social Care Research & Information
Cc: [REDACTED]
Subject: RE: Application for PhD Research Access

Dear [REDACTED]

Excellent, and thank you again for your time and consideration.

Best wishes,
Alex

From: [REDACTED] On Behalf Of Health & Social Care Research & Information
Sent: 25 September 2015 14:24
To: WRIGHT Alex <alex.wright@ed.ac.uk>; Health & Social Care Research & Information
[REDACTED]
Cc: [REDACTED]
Subject: RE: Application for PhD Research Access

Hi Alex

Thanks for sharing your methods.

I've copied [REDACTED] into these emails. Unless [REDACTED] has any concerns ([REDACTED] out of the office until Monday 28th), yes, I can confirm that we would be happy with you to proceed.

Many thanks

[REDACTED]
[REDACTED] | Research and Information Officer | The Department of Health and Social Care | [REDACTED]
[REDACTED]

From: WRIGHT Alex [<mailto:alex.wright@ed.ac.uk>]

Sent: 25 September 2015 14:17

To: Health & Social Care Research & Information

Subject: RE: Application for PhD Research Access

Dear [REDACTED],

Thank you very much for your email, this is excellent news.

With regards to recruiting participants, I am planning to initially contact the members of the [REDACTED], as listed on their website. This initial contact will likely be made by email, to which I will attach a short summary of my research and will emphasize that their participation would be entirely voluntary. From there, I will ask the [REDACTED] members about other relevant stakeholders/potential interviewees who have been involved in implementing the Alcohol Strategy within [REDACTED]

I would welcome any comments about this plan from your office.

To confirm, does your below email constitute my official permission to proceed with this research? Please let me know if any further paperwork or official procedure is required.

Thank you very much again for your consideration, I look forward to conducting this project and to working with [REDACTED]

Best wishes,
Alex

Alexandra Wright, MSc
PhD Candidate (International Public Health Policy)

What Works Scotland
<http://whatworksscotland.ac.uk/>
School of Social and Political Science
University of Edinburgh
E-Mail: alex.wright@ed.ac.uk
Phone: +44(0)7582151540



From: [REDACTED] On Behalf Of Health & Social Care Research & Information
Sent: 25 September 2015 14:01

To: WRIGHT Alex <alex.wright@ed.ac.uk>
Cc: [REDACTED]
Subject: FW: Application for PhD Research Access

Hello Alex

Thank you for submitting your Research Access Form and supporting documentation. This sounds like a very interesting piece of work and your supporting documentation appears to cover all areas.

As [REDACTED] has expressed his support with this, we are happy for you to progress. Do you know how you are going to recruit participants?

Many thanks

[REDACTED]

[REDACTED] | Research and Information Officer | The Department of Health and Social Care | [REDACTED]
[REDACTED]

From: WRIGHT Alex [<mailto:alex.wright@ed.ac.uk>]
Sent: 20 September 2015 18:05
To: Health & Social Care Research & Information
Subject: Application for PhD Research Access

Dear Research Access Requests Team,

My name is Alexandra Wright and I'm a PhD student in International Public Health Policy at the University of Edinburgh. I'm writing to apply for Research Access to [REDACTED] for the purposes of carrying out a portion of my PhD research.

As outlined in my application, my PhD aims to inform health policy implementation by generating knowledge on the case of implementing Scotland's Alcohol Strategy at Local Authority level. I am therefore requesting permission to interview managerial-level staff [REDACTED] who have been involved in the process of implementing Scotland's Alcohol Strategy [REDACTED]. My application follows multiple conversations I have had with [REDACTED] manager [REDACTED] Alcohol and Drug Partnership, who has expressed support for this project.

Please find attached all supporting documentation for this application, including the Research Access Questionnaire, ethics documentation, and proposed interview questionnaire.

Please do not hesitate to contact me with any questions or concerns, as I'm happy to provide any further information required about my proposed project. Thank you very much for your consideration of my application, and I look forward to hearing from you.

Sincerely,

Alex Wright

Alexandra Wright, MSc
PhD Candidate (International Public Health Policy)

What Works Scotland
<http://whatworksscotland.ac.uk/>
School of Social and Political Science
University of Edinburgh
E-Mail: alex.wright@ed.ac.uk
Phone: +44(0)7582151540

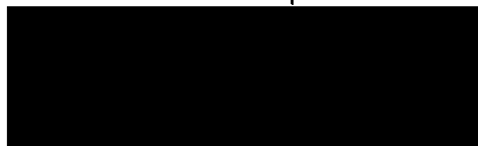


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Research & Development



Alexandra Wright
Department of Social Policy
Chrystal Macmillan Building
15A George Square
Edinburgh
EH8 9XF

Date 20 June 2016

Your Ref

Our Ref



Enquiries to

Extension

Direct line

Fax

Email



scot.nhs.uk

Dear Ms Wright

The use of evidence in health policy implementation: a case study of Scottish Alcohol Policy

I have reviewed your proposal and have determined that it is not appropriate to classify it as Research according to the guidance issued by the NHS National Research Ethics Service (NRES).

The NRES guidance is outlined in a summary leaflet which can be accessed via their website at: <http://www.nres.nhs.uk/search/?q=service+evaluation>.

The leaflet contains a helpful summary table, a portion of which I have reproduced at the end of this letter for your reference.

As the project is not research, it does not require to be reviewed by an NHS Ethics Committee, and does not require formal R&D Management Approval to be undertaken within [redacted].

I would, however, like to highlight a number of issues that you should consider when carrying out your project:

- As your project has not been defined as Research, it will not be managed as such, nor will it be subject to regular review or monitoring by the R&D Department. Furthermore, you should avoid referring to it as research in any paper or presentation.
- You should ensure that you have agreement of [redacted] to carry out your project in their area.
- You should be aware of any potential ethical issues, discuss these with colleagues and advisors, if necessary, and ensure patient safety as your first priority.

- You should comply with all relevant Health and Safety and Data Protection legislation and guidance, and avoid using patient identifiable information unless it is essential – seek guidance from the Information Governance department if required ([REDACTED]scot.nhs.uk).
- You should ensure that all confidential information is maintained in secure storage.
- You should maintain a well organised project file at all times, including copies of any agreements, protocols questionnaires etc.
- You should seek to publish the results of your work as widely as possible.
- If you make changes to the protocol in the future, please resubmit the paperwork to Research and Development for review, as this might change the status of the project.

Good luck with your project and if you require any assistance in the future please don't hesitate to contact us.

Yours sincerely

[REDACTED]

[REDACTED]

Head of Research & Development

Cc.

[REDACTED]

WRIGHT Alex

From: [REDACTED] (NHS [REDACTED]) [REDACTED]
Sent: 28 July 2016 10:46
To: WRIGHT Alex
Cc: [REDACTED]
Subject: RE: PhD Student - Ethics Query

Hello Alex

Thanks for completing your form. This all looks in order and I note that you have agreement from local managers to undertake this project. We will go ahead and register and look forward to hearing how you get on

Thanks

[REDACTED]

[REDACTED]

Clinical Governance Manager

[REDACTED]

-----Original Message-----

From: WRIGHT Alex [mailto:alex.wright@ed.ac.uk]
Sent: 28 July 2016 09:47
To: [REDACTED]
Cc: [REDACTED]
Subject: Re: PhD Student - Ethics Query

Dear [REDACTED]

Thank you for your email and the form for registering a project. Please find the completed form attached, for my PhD project: "The use of evidence in local policy implementation: a case study of Scotland's Alcohol Strategy".

Is anything further I need to do in order to attain approval for conducting this work in [REDACTED]

Please also don't hesitate to let me know if you have any further questions.

Thank you and best wishes,
Alex Wright

On 2016-07-22, 4:28 PM, [REDACTED] wrote:

>Hi Alex

>

>Please see attached the form we ask people to complete to register
>their project

>

>Please let me know if you require any further information

>

>I look forward to hearing from you

>

>

>Thanks

>

>[REDACTED]

>

>[REDACTED]

>Clinical Governance Manager

[REDACTED]

>

>

>-----Original Message-----

>From: WRIGHT Alex [mailto:alex.wright@ed.ac.uk]

>Sent: 20 July 2016 17:34

>To: [REDACTED]

>Subject: Re: PhD Student - Ethics Query

>

>Dear [REDACTED]

>

>[REDACTED] many thanks for your quick reply.

>

>[REDACTED] please let me know if you require any further information beyond the documents being forwarded to you -
>I'm happy to answer any questions about the study. I look forward to hearing from you when you've had a chance to
>consider my proposed work in [REDACTED]

>

>Thanks again and best wishes,

>Alex

>

>

>

>

>On 2016-07-20, 5:28 PM, [REDACTED] wrote:

>

>>Dear Alex

>>

>>As I said in my previous email, if you are doing a service evaluation it does not need REC or R&D approval and this
>>would be the same across Scotland. You would need to log it for [REDACTED] with [REDACTED] (copied in) but it would not
>>require a letter of approval per se. [REDACTED] can you pick this up please? I will forward docs to you [REDACTED]

>>

>>Regards

>>

>> [REDACTED] is Clinical Governance Manager for [REDACTED]
>> [REDACTED]
>> [REDACTED]
>>
>>Regards
>> [REDACTED]
>>
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED] Alcohol & Drugs Partnership
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>>E-mail: [REDACTED]
>>
>>
>>
>>-----Original Message-----
>>From: [REDACTED]
>>Sent: 20 July 2016 16:25
>>To: [REDACTED]
>>Cc: [REDACTED]
>>Subject: RE: Ethics Query
>>
>>Hi [REDACTED]
>>
>>If it is a service evaluation regardless of whether patients are
>>involved it does not require NHS Research Ethics or R&D Management
>>Approval. If it is research i.e. is asking a research question(s) and
>>involves patients (identified as patients through one route or
>>another) it either has to go for Proportionate Review with NHS
>>Research Ethics and for R&D management approval (this is where
>>participants would be involved in interviews focus gps or the like) or
>>for Full Review with the NHS Research Ethics and for R&D Management
>>Approval (this is where participants would be involved by having some
>>form of intervention or action either physical or other therapy). This
>>would be the same across Scotland..if service evaluation then every
>>R&D office should say the same. In [REDACTED] SEs are logged by [REDACTED]
>> [REDACTED] in Clinical Governance (copied in)
>>
>>Regards
>> [REDACTED]
>>Research, Development & Innovation Manager [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>>
>>From: [REDACTED]
>>Sent: 20 July 2016 14:13
>>To: [REDACTED]
>>Subject: Ethics Query
>>
>>Hi [REDACTED]

>>
>>I am wondering if you can help. [REDACTED] Alcohol & Drugs Partnership has been contacted by a PhD student undertaking some research into the implementation of Scotland's Alcohol Strategy, and we are keen to be involved [REDACTED] The researcher has asked the following:
>>I would like to confirm what ethical approval I will need from [REDACTED] to conduct this research. I already have ethical approval for this project from the University of Edinburgh, the paperwork for which I have attached to this email. For my first ADP I required ethical approval from the local Council, while in my second ADP I required a letter from NHS ethics (for which my project counts as a 'service evaluation', not a full research project, because of the types of people I'm interviewing). Do you have a sense of what ethics approval I may need to attain for [REDACTED] or who I should ask about this?
>>Could you advise on this, or signpost me to the relevant person(s).
>>
>>Regards
>> [REDACTED]
>>
>> [REDACTED]
>> [REDACTED]
>> [REDACTED] Alcohol & Drugs Partnership
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>>E-mail:
>> [REDACTED]
>>n
>>hs.net>
>>
>>
>>
>>*****
>>*
>>*****
>>
>>This message may contain confidential information. If you are not the
>>intended recipient please inform the sender that you have received the message in error before deleting it.
>>Please do not disclose, copy or distribute information in this e-mail or take any action in reliance on its contents:
>>to do so is strictly prohibited and may be unlawful.
>>
>>Thank you for your co-operation.
>>
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>> [REDACTED]
>>*****
>>*
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>>*****
>>
>>

APPENDIX 12 – Project Ethics Package

ORIGINAL CONSENT FORM

What Works Scotland funded PhD

“Complex implementation: a case study of Scotland’s Alcohol Strategy”

Consent Form

Alexandra Wright

PhD Student

School of Social and Political Science

University of Edinburgh

Edinburgh, EH8 9LD

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
3. I agree to take part in the above study.

☐☐☐

Please tick box
Yes No

4. I agree to the interview consultation being audio recorded and transcribed
5. I agree to the use of anonymised quotes in publications, in which I may be identifiable
- OR**
6. I agree to the use of anonymised quotes in publications only if I am unidentifiable
7. I agree to the use of anonymised data in publications in which my employer may be identifiable
- OR**
8. I agree to the use of anonymised data in publications only if my employer is unidentifiable

☐☐☐☐☐☐☐☐☐☐

*I agree to be identified as:

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

PARTICIPANT INFORMATION SHEET

“Local implementation of national health policy: a case study of Scottish alcohol policy”

Please take time to read the following information and discuss it with others if you wish. It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep. You will also be asked to sign a consent form. You can change your mind at any time and withdraw from the study without explanation and without penalty.

INVITATION

You are being asked to take part in a research study to examine uses of evidence within the process of implementing Scottish alcohol policy in selected Local Authorities. We would like to interview you to ask you about your opinions on how the Alcohol Strategy was implemented at local level and the use of information or evidence by local actors in this process. You have been chosen because you are a key stakeholder in the process of alcohol policy development and/or implementation. The overarching aim of this research is to generate knowledge on national policy implementation processes at local level.

This research is part of a PhD project at the University of Edinburgh. The Principal Investigator on the project is Alexandra Wright. The research is being supervised by Dr Katherine Smith, Reader in Global Health Policy at the University of Edinburgh, and Dr Sarah Morton, Co-Director (Knowledge Exchange) at the Centre for Research on Families and Relationships at the University of Edinburgh. The research is being funded by What Works Scotland (www.whatworksscotland.ac.uk), an initiative to improve the way local areas in Scotland use evidence to make decisions about public service development and reform. What Works Scotland is funded by the Scottish Government and the Economic and Social Research Council.

This project has been approved by the Ethics Committee of the School of Social and Political Science at the University of Edinburgh.

WHAT WILL HAPPEN

In this study, you will be asked to participate in a semi-structured interview with Alexandra Wright regarding your opinions about the implementation of alcohol policy in Scotland and the uses of information and evidence in this process. If you consent to participate, Alexandra Wright will meet with you at a time and place convenient for you.

The audio from the interview will be recorded and then transcribed onto a computer. The audio recordings and transcriptions will be anonymised and kept on a computer that is protected from intrusion with username and password. The audio recordings will be destroyed at the end of the study. Your responses will be treated with full confidentiality. Anyone who takes part in the research will be identified only by their generic professional role (e.g. “researcher”).

You can request a copy of the interview transcript if you wish. The interviews will be analysed by Alexandra Wright using a qualitative data software package.

TIME COMMITMENT

The interview will take approximately one hour and will likely be conducted during one session. It will be possible to take a break or stop at any point during the interview. Follow-up sessions will be conducted only as needed, for example if you feel you have more you would like to say.

PARTICIPANTS' RIGHTS

You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn or destroyed. You have the right to omit or refuse to answer or respond to any question that is asked of you without penalty.

You have the right to have your questions about the research answered (unless answering these questions would interfere with the study's outcome). If you have any questions as a result of reading this information sheet, please ask Alexandra Wright or one of her supervisors before the study begins.

BENEFITS AND RISKS

There are no known benefits or risks for you in this study.

COST, REIMBURSEMENT AND COMPENSATION

Your participation in this study is voluntary.

CONFIDENTIALITY/ANONYMITY

The data we collect do not contain any personal information about you except the professional role that you wish to be identified by, as written on your consent form. The data collected and analysed by Alexandra Wright will be written up for inclusion within her PhD Thesis, the results of which may be published academic venues such as peer reviewed journals and conference presentations. The results of the research may also lead onto further studies. No individual research participant will be identifiable from any publications.

FOR FURTHER INFORMATION

Alexandra Wright, Dr. Katherine Smith, or Dr. Sarah Morton will be glad to answer your questions about this study at any time. Please find their individual contact information below. If you have any concerns about any aspect of the research or the conduct of the researcher, please contact Dr Smith or Dr Morton.

Alexandra Wright	07582151540	alex.wright@ed.ac.uk
Dr Katherine Smith	0131 651 1323	Katherine.smith@ed.ac.uk
Dr Sarah Morton	0131 651 1832	S.Morton@ed.ac.uk

If you want to find out about the final results of this study, please contact Alexandra Wright at the above email address. Thank you for taking the time to read this information sheet.

Full Contact Details:**Alexandra Wright, MSc**

PhD Candidate, International Public Health Policy
Global Public Health Unit, School of Social and Political Science
University of Edinburgh
Edinburgh, UK, EH8 9YL
Phone: +44 (0) 7582 151 540
Email: alex.wright@ed.ac.uk

CONSENT FORM

Working title: *Local implementation of national health policy: a case study of Scottish alcohol policy*

A) Participation Details

Please tick box

Yes

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason and without penalty.

☐

3. I agree to take part in the above study.

☐

4. I agree to the interview consultation being audio recorded and transcribed.

☐

B) Identification Details

For the below two questions, please tick whichever box is most appropriate for you.

5. *Personal Identification*

I agree to the use of anonymised quotes in publications, in which I may be identifiable by my generic professional role, as described below.*

☐

*I agree to be identified as:

Name of Participant (please print)

Signature

Date

APPENDIX 13 – Wright (2019)



Article

Local Alcohol Policy Implementation in Scotland: Understanding the Role of Accountability within Licensing

Alex Wright

Global Health Policy Unit, Social Policy, School of Social and Political Science, University of Edinburgh, Edinburgh, EH8 9LD, UK; alex.wright@ed.ac.uk; Tel.: +44-(0)-131-6504147

Received: 30 March 2019; Accepted: 20 May 2019; Published: 28 May 2019



Abstract: Scotland has been ambitious in its policy and legislative efforts to tackle alcohol-related harm, efforts which include the innovative feature of a ‘public health objective’ within local alcohol licensing. However, the persistence of alcohol-related harms and inequalities requires further examination of both the overarching Scottish alcohol strategy and its specific implementation. A qualitative case study was undertaken to explore how alcohol policy is implemented locally in Scotland, with data generated from (i) documentary analysis of 12 relevant policies, legislation, and guidance documents; and (ii) a thematic analysis of semi-structured interviews with 54 alcohol policy implementers in three Scottish localities and nine national-level stakeholders. The data suggest there is a tension between the intentions of licensing legislation and the way it is enacted in practice, and that accountability emerges as an important factor for understanding why this occurs. In particular, there are a lack of accountability mechanisms acting upon Scottish Licensing Boards to ensure they contribute to the public health goals of the Scottish alcohol strategy. From a public health perspective, this has perpetuated a system in which Licensing Boards continue to act with autonomy from the rest of the alcohol policy implementation system, creating a challenge to the achievement of public health goals. Alcohol policy in Scotland is likely to fall short of intended goals as long as the tension between licensing legislation and enacted licensing practices remains.

Keywords: alcohol policy; licensing; accountability; policy implementation; Scotland

1. Introduction

This study examines the ‘how and why’ of Scottish alcohol policy implementation. A key finding which emerged from the study was the importance of accountability, particularly within the context of Scotland’s alcohol licensing regime. This article focuses on explaining how accountability mechanisms within Scotland’s licensing regime can present challenges to the effective implementation of alcohol policy. This is important because limited empirical research has examined how processes of accountability within alcohol licensing influence Scottish alcohol policy implementation and the related pursuit of public health goals. This study investigates this problem by undertaking a qualitative case study, using documentary analysis of national policy, legislation and guidance, and interview data with national and local alcohol policy implementation stakeholders.

In Scotland, alcohol misuse is an important public health policy problem; high levels of alcohol consumption have contributed to patterns of health inequalities and led to correspondingly high rates of alcohol-related harms and costs [1]. To address these issues, the Scottish Government developed policy and legislation to prevent and address alcohol-related harms. The government’s central policy, *Changing Scotland’s Relationship with Alcohol: A Framework for Action*, was published in 2009 [2]. It outlines a ‘whole population approach’ as a key feature [1] and has been lauded as being ‘evidence-informed’ [3].

An additional innovative feature of the government's overall approach has been the inclusion of a 'public health objective' within licensing legislation, namely the *Licensing (Scotland) Act 2005*.

Extensive evaluations of population health outcomes have also been undertaken in relation to Scottish alcohol policy [4]. These have demonstrated, for example, that while alcohol-related death rates in Scotland peaked in the mid-2000s and then began to fall, this trend has stalled and, since 2012, rates have been increasing again [5,6]. Additionally, while inequalities in alcohol-related deaths in Scotland have narrowed over time, alcohol-related mortality rates remain more than eight times higher in the most deprived areas compared with least deprived areas [5]. It is apparent that while some progress has been made in tackling alcohol-related harm, there is a continued need for the effective implementation of the evidence-informed measures embedded in Scottish alcohol policy.

In light of this, there is a need to understand the challenges and facilitators of Scottish alcohol policy implementation—a contribution this article seeks to make, with a specific focus on alcohol licensing and the emergent theme of accountability. This article is timely given recent policy developments within Scottish Government which will need to be implemented effectively. This includes the publication in late 2018 of new Scottish alcohol policy [7,8] to improve health through the prevention of alcohol- and drug-related harm and a revised draft of the *Guidance for Licensing Boards* which, at time of writing, is out for consultation [9].

Scottish Alcohol Licensing: Policy Context, Existing Research and Accountability

While the current Scottish approach to alcohol policy has been led by a Scottish National Party (SNP) government, there has been notable cross-party support for an alcohol strategy generally, providing a supportive political context for this issue. The context is complicated, however, by the Scottish Parliament and Government's constrained capacity to act only on elements of alcohol regulation which have been devolved to them by the UK Government [10]. Additionally, the past few years have seen substantive policy and political energy at a national level dedicated to the development and enactment of legislation for minimum unit pricing (MUP) of alcohol [11]. The Scottish Parliament passed MUP legislation in 2012, but was then forced to fight a protracted legal battle in European and UK courts against a challenge brought by the Scotch Whisky Association [12]. The government's case was eventually successful, and MUP was implemented in May 2018; however, in the meantime, other local processes of alcohol policy implementation were facing their own challenges. Within this context, this study was concerned with the ongoing implementation of the range of other alcohol policy measures in the Scottish alcohol strategy, including localized decision-making (e.g., licensing) by locally elected representatives and other stakeholders such as Alcohol and Drug Partnerships (ADPs).

Alcohol licensing is a key competency devolved to the Scottish Parliament from the UK Government in Westminster. The *Licensing (Scotland) Act 2005* (referred to here as LA 2005), helps to structure the legislative and regulatory framework for licensing and makes provisions for the regulation of the sale of alcohol and the premises on which alcohol is sold. LA 2005 gives local Licensing Boards (LBs) the responsibility for granting or rejecting alcohol licenses and thus helps to determine the availability of alcohol in local areas. The membership of these LBs is constituted of locally elected councillors.

Critically, LA 2005 contains five 'licensing objectives', and requires LBs to be concerned with each: (i) Preventing crime and disorder; (ii) securing public safety; (iii) preventing public nuisance; (iv) protecting and improving public health; and (v) protecting children from harm. There are intersections across all five objectives, and all potentially run counter to economic interests invested in alcohol sales. Of these, however, the implementation of the 'public health objective' is most relevant for this article, and it was primarily in relation to this objective and the policy context surrounding it that accountability emerged as an explanatory factor.

In the UK, Scotland is unique for including the protection of public health as a statutory objective in its licensing legislation [3,13]. Indeed, the Scottish alcohol strategy identifies alcohol licensing as a key component of their 'whole-population approach' to combating alcohol-related harm, and it identifies licensing stakeholders as having a key role in helping to achieve the strategy's public health goals.

The public health objective gives LBs a duty to assess the number and density of licensed premises in their area—a key measure if one is concerned with the availability of alcohol. This is operationalized in the concept of ‘overprovision’, which refers to an “assessment that there are too many licensed premises in a particular locality either in terms of the number of premises, the capacity of premises, the type of premises, or the size of a display area” (p. vi, [14]). By distinguishing a given area as overprovided for, LBs have policy grounds to refuse new license applications in this area.

In Scotland, the assessment of whether overprovision exists happens during the development of each LB’s ‘Licensing Policy Statement’ which “sets out the general approach a Licensing Board will take to regulating the sale of alcohol and licensed premises in its area” (p. 2, [15]). Importantly, the Statement must include a declaration of how each LB will progress towards each of the five licensing objectives, and LBs must make their licensing decisions with consideration to their Policy Statement [15].

In terms of policy practice, alcohol licensing in Scotland occurs in local government, where local councils and their respective elected councillors have a certain level of autonomy from the Scottish Government. This is grounded in a Concordat signed by the Scottish Government in 2007 with the Convention of Scottish Local Authorities (COSLA), which removed certain controls that the government had over councils [16]. This has implications for LB members’ role in alcohol policy implementation, since their status as councillors means they are not automatically obligated to follow Scottish Government-identified priorities (e.g., to commit to a whole-population approach to tackling alcohol-related harm). However, this autonomy is complicated by the government’s parallel implementation of the National Performance Framework, an instrument first implemented in 2007 (and recently revised in 2018) which defines the government’s ‘purpose’ and overarching goals [17]. As part of the aforementioned Concordat, local governments have to identify their local priorities through community planning and demonstrate how these contribute to the National Performance Framework [16].

A range of organisations are stakeholders in Scottish alcohol policy enactment; these include the Scottish Parliament and Scottish Government, national governmental organisations concerned with health, and local entities such as local authorities, local partnerships, and local communities. The specific focus in this article is the relationships of LBs with both the Scottish Government and local Alcohol and Drug Partnerships (ADPs). The membership and responsibilities of each are shown in Table 1 below.

Table 1. Membership and Responsibilities of Scottish Alcohol Policy Implementation Stakeholders.

Membership		Responsibilities Regarding Alcohol Policy Implementation
Scottish Government	Elected Ministers and unelected civil servants	Designated government teams are responsible for developing national alcohol policy and supporting its implementation.
Licensing Boards	Elected Local Councillors	Boards preside over the local alcohol licensing system, which controls alcohol availability [18].
Alcohol and Drug Partnerships	Range of statutory (e.g., health, police, social work, education, fire service) and non-statutory (e.g., third sector) representatives	These partnerships are tasked with local alcohol policy implementation. ADPs develop local alcohol strategies which serve to translate and tailor the national alcohol strategy to local needs.

Research on the interplay between local alcohol availability and health has proliferated in recent years in the UK, and this research demonstrates both that availability is associated with population harm [19–21] and that policies to regulate availability can have a positive impact on population health [22]. For example, Richardson et al. (2015) have demonstrated that in Scotland, a higher alcohol outlet density in a given neighbourhood is associated with higher alcohol-related hospitalisations and deaths [20], while research from the broader UK context suggests stricter licensing enforcement to regulate alcohol availability may have a positive effect on alcohol-related hospitalisations [23]. Note, however, that existing research on outlet density is not definitive in providing policy

decision-makers with density thresholds that should not be exceeded. Therefore, licensing decisions informed by this work will remain interpretative. Further, while criticisms of this area of literature have noted limitations in terms of methodological approaches and scope [24], as well as the currently inability to demonstrate causality [25], existing research indicates the importance of local licensing decision-making on population health outcomes.

In addition to the association between alcohol availability and harm, research has also studied the licensing policy context [13,26] and different aspects of licensing processes. In the Scottish context, an in-depth evaluation of the implementation of LA 2005, an evaluation which found a number of key challenges that prevented effective implementation of this legislation [14]. These included a lack of updated implementation guidance and the inconsistent manner in which national and local data was being collected [14].

An additional key issue evident in the literature has been the interplay of evidence used within licensing processes. In particular, research has suggested that public health evidence has limited impact on licensing decision-making, and LB members more often rely on their own values and beliefs, or anecdotes from their constituencies, to inform their decisions [27]. Further, that while public health interviewees in this study perceived themselves to be approaching their work with a ‘whole-population approach,’ the same perspective was not always adopted by other licensing stakeholders (i.e., LB members) [27]. These results have highlighted a possible tension between the perspectives, goals, and priorities among different licensing stakeholders.

While the above research contributes to an understanding of licensing processes, there remains a limited body of empirical research in the UK and Scottish contexts reporting exactly how key stakeholders are being held accountable for their role in effectively implementing licensing policy or how the accountability regime(s) surrounding licensing influence alcohol policy implementation. Indeed, recent work by Fitzgerald and colleagues [28] is unique in its explicit inclusion of accountability as a theme in their analysis of Scottish licensing. Their research reported (i) a lack of mechanisms available to influence the councillors who were members of local LBs and (ii) that LB convenors and licensing clerks had the power to shape a given LB’s attitude towards public health. Further, that the latter situation sometimes resulted in challenges to local public health progress and variations across local areas in terms of how the public health objective was perceived and implemented. As will be shown in the results and discussion sections, this article helps to reaffirm and build upon those authors’ work.

Overall, however, specific in-depth inquiries into accountability in alcohol policy implementation, remain limited, and findings are not linked to existing accountability literature, a substantive area of research from which theoretical and empirical lessons may be drawn. While literature on alcohol policy implementation studies have sometimes discussed accountability-related issues (e.g., in relation to power in licensing processes [28], the importance of clearly establishing responsibility for particular interventions [29], or policy stakeholders’ compliance with and navigation of relevant alcohol legislation [14,30]), a notable gap in published research exists which draws explicitly upon lessons from accountability scholarship to empirically examine alcohol policy implementation processes. Given the emergence in this research of accountability as an explanatory factor influencing implementation of Scottish licensing policy, this article seeks to contribute understanding to this gap.

Indeed, the issue of accountability, a concept used extensively (albeit often somewhat opaquely) in public discourse, is somewhat rarely empirically examined within broader health policy implementation research. In a literature review of empirical health policy implementation studies conducted for the Scottish Parliament’s Information Centre [31], only a small number of empirical articles explicitly linked accountability and health policy implementation processes (e.g., Kelly et al. [32] and O’Toole et al. [33]). This is despite authors within public policy and implementation literature identifying accountability as being fundamental to policy implementation. For example, Jan-Erik Lane [34] has written that the implementation gap between policy expectations and outcomes is inherently related to accountability.

The current paper is situated in the context of the existing regulatory and accountability framework for licensing stakeholders—LBs in particular. Table 2 outlines the relevant provisions regarding accountability of LBs as stated in existing legislation.

Table 2. Legislative provisions regarding Licensing Board accountability.

Legislation	Relevant Provisions Regarding Accountability of Licensing Boards
Licensing (Scotland) Act 2005	<ul style="list-style-type: none"> • Mandates that the Board produce a Licensing Policy Statement once every three years, which provides a locally-specific legal basis for their decision-making. • Mandates that the Licensing Statement include statement on whether local areas are overprovided for (enacted 2009). • Outlines the five licensing objectives, including protecting and improving public health.
Alcohol etc. (Scotland) Act 2010	<ul style="list-style-type: none"> • Makes modifications to mandatory conditions of premises and occasional licences which were in the 2005 Act. • Sets out actions Licensing Board must undertake before and after it makes a variation to premises licence conditions. It also states that a variation to licence conditions may be made only where the Board is satisfied that the variation is necessary or expedient for the purposes of any of the licensing objectives. • Amends the 2005 Act to add the relevant Health Board to the bodies that the Licensing Board is required to consult when developing their Licensing Policy Statement, a Health Board which must also be notified of any premises licence applications.
Criminal Justice and Licensing (Scotland) Act 2010	<ul style="list-style-type: none"> • Makes modifications to the 2005 Act regarding application notification requirements, occasional licenses, hours, etc.
Air Weapons and Licensing (Scotland) Act 2014	<ul style="list-style-type: none"> • Mandates Licensing Boards submit annual reports of functions to the Scottish Government, which must include a statement explaining how the Board has had regard to the licensing objectives and their Licensing Policy Statement when carrying out its functions.

In relation to this legal framework and the policy context described above, this article seeks to address the existing knowledge gap at the intersection of Scottish alcohol policy implementation, licensing, and accountability. It asks whether the ways LBs are held accountable function to support implementation processes and corresponding public health goals in the context of Scotland's national alcohol strategy. Towards this aim, this article examines how LBs, as administrative and quasi-judicial entities that exist beyond the traditional health arena, can have important impacts on implementation processes and subsequent health policy outcomes.

2. Methods

This research was conducted as part of a doctoral research project which aimed to generate understanding about how and why Scotland's national alcohol strategy was implemented in local areas. This overarching study aim lent itself to using a qualitative case study approach to attain a rich, 'thick' description of processes within Scottish alcohol policy implementation. Ethical approval for this study was granted by the School of Social and Political Science at the University of Edinburgh.

Three purposely selected local authority areas (referred to here as 'local areas') across Scotland served as the study sites in order to explore similarities and differences in alcohol policy implementation across different settings. The three local areas were selected using an established sampling framework from Miles and Huberman [35], which incorporates theoretical and pragmatic considerations such as whether the sample plan is feasible, ethical, and has the potential to generate rich information. Within the framework, a researcher also has the flexibility to account for other relevant considerations; for example, in this study, sites were selected to attain a diversity of urban and rural locations.

Ultimately, one urban (LA1), one mixed urban-rural (LA2), and one rural (LA3) site agreed to participate in this study, and ethical approval was attained from the relevant authority in each prior to data collection.

Data were generated from the analysis of policy documents and semi-structured interviews. The approach to documentary analysis followed Mason in viewing the content of key policy documents as constructed representations of a formal decision (or set of decisions) taken by those with authority in the Scottish alcohol policy system [36], as well as providing insights into the values underlying these policy decisions [37]. These insights were needed to help to understand the representations of policy implementation in the documents (in terms of both process and outcomes) and whether they contained information about the policy context and about the roles and expectations of alcohol policy implementers (i.e., LBs or ADPs). In contrast, the use of interviews allowed an understanding of the perceptions of alcohol policy implementers themselves regarding how they undertook policy implementation practice. These data were generated from semi-structured interviews with national-level alcohol policy stakeholders and local alcohol policy implementers.

Overall, a documentary analysis of 12 relevant national policies, legislation, and reports was undertaken. The analysis was guided by Walt and Gilson's [38] Triangle Framework for health policy analysis, which focuses on actors, context, process, and content. While local policy documents (e.g., LBs' Statement of Licensing Policy) were read by the author, they were not formally reported on within the study to preserve the anonymity of each participating local area.

For the interviews, national interviewees ($n = 9$) were recruited if they were currently involved in the development and delivery of alcohol policy and/or legislation in Scotland or if they had been involved in the development of the 2009 *Framework for Action*. This included a range of representations across public and third sector organisations. Local interviewees were recruited from the three selected local areas' respective LBs ($n = 8$) and ADPs ($n = 46$) (Table 3).

Table 3. Number of local- and national-level interviewees.

Sector	Number of Interviewees by Local Area and Nationally		
	LA1	LA2	LA3
Licensing Board Members	4	1	3
Other local alcohol policy implementers (e.g., ADP members)	13	15	18
National Level Alcohol Policy Stakeholders		9	

ADPs are local, multi-sectoral partnerships tasked by the Scottish Government with carrying out alcohol policy implementation; their membership includes, for example, representatives from the local health board, police, community justice, social work, education, and the third sector [39]. There is a total of 30 ADPs across Scotland, which are usually matched geographically with the boundaries of their respective local authority area. ADPs do not have a formal relationship with LBs; however, certain ADP members (specifically police and health) are 'statutory consultees' to the LB, meaning they have the right to be informed when a license application is submitted and to lodge an objection to that application if they wish. They do not, however, have a role in the decision about whether to grant a licence. Further, ADPs and their members work within a context of 'community planning'—mandated collaborative working of public services and communities to design and deliver services—established in Scotland in 2003 [40,41]. In each local area, a 'Community Planning Partnership' (CPP) is responsible for determining local policy priorities—organizations such as ADPs report to the CPP, while LBs do not.

All interviewees were recruited directly via email, and interviewing took place between December 2015–January 2017. Interviews ranged from 40 minutes to two hours in length, and each was audio recorded with the interviewee's consent. The interview schedule was developed on the basis of literature on alcohol policy and policy implementation. Interviews were analysed thematically [42] in NVivo 10 [43] using a combination of deductive and inductive approaches [44,45].

For the deductive coding, provisional codes were created based on the study's research questions, the author's understandings of relevant policy implementation literature, and recollection of the interviews themselves. For the inductive coding, new codes were generated a posteriori from the data as new themes, topics, or concepts were identified within the transcripts. Analysis of interviews and documents occurred in parallel.

Data generated around the theme of accountability provided rich, meaningful information about the actions of alcohol policy implementers. While multiple types of formal and informal accountability emerged from the data, this article reports on the 'public-administrative' accountability of licensing decision-makers, a type of accountability which examines vertical or hierarchical accountability relationships—with regards to political or legal interactions, for example [46]. Thus, the analysis investigated accountability mechanisms and arrangements in which one organisation is held accountable by another who is 'higher' in the formal governance hierarchy.

The combination of documentary data and interview data provided both official government documentation of stated intentions with regards to the alcohol strategy and first-hand accounts of alcohol policy implementation practice, respectively. The multiple sources of data were integrated to find where there was alignment or tensions between formally written or stated expectations of alcohol policy implementation and what was enacted in practice. As noted, following the emergence of accountability as an important theme in the broader research project, this article is concerned with potential differences between expectations and practice through the lens of accountability within alcohol licensing. In particular, the focus here is whether the licensing accountability regime as structured and enacted presents challenges or enables Scottish alcohol policy implementation.

3. Results

3.1. Perspectives on the Licensing Objectives and Importance of Accountability

Within interviews, LB members and other licensing stakeholders discussed the licensing objectives, contrasting the public health objective with the priority afforded to the other objectives. In particular, it was reported that the public health objective had not yet led to major changes in how licensing stakeholders operated in relation to public health concerns:

"I think [the public health objective] has always been the poor cousin of the five licensing objectives. It's a difficult one for the Board to deal with, because an application where there are issues of disorder, or public nuisance, noise, whatever, in an immediate area, that's quite clear ... and the police might provide evidence to that effect ... they can tie in a refusal with the kind of disorder and public nuisance licensing objectives. Public health has always been more of a difficult one for the Board ... the Board doesn't really see favour with overprovision as a concept"

(LA1, job title withheld)

One of the key explanations for these challenges associated with implementing the public health objective was the accountability arrangements surrounding LBs. For example, one ADP member reported on frustrations being raised across organisations involved in local alcohol policy implementation, in relation to the lack of accountability surrounding LBs:

"[We were] ... working with the police and the NHS, to try to influence the Licensing Board, nothing really happening, and then that frustration coming back at the Community Planning Partnership level because they can't influence it either. So yeah, Licensing Boards, because of legislation, are sitting out here doing as they please without any accountability."

(LA1, ADP Member)

3.2. Legal Accountability of Licensing Boards

Legal accountability is a type of accountability in which expectations are based on legal norms and rules and are enforced by legal bodies (e.g., courts) [47]. As previously noted in Table 2, multiple pieces

of legislation determine the legal obligations of LBs. However, while this legislation provides the legal accountability framework for LBs, the data suggest LBs have certain flexibility in enacting this framework, which has implications for how they contribute to the public health-related aspects of the legislation and Scotland's whole-population approach overall.

An example of this is in their development of overprovision statements. LA 2005 has the accompanying *Guidance for Licensing Boards and Local Authorities*, which notes the duty of LBs to assess overprovision in their area; it also notes that LBs were meant to make an "accurate assessment of overprovision" [48]. However, the *Guidance* does not specify what an 'accurate' assessment was to entail. The only existing legal stipulation is that LBs must demonstrate they have considered the number and capacity of licensed premises in the area and have conducted certain mandatory consultations with, for example, statutory services and the public. However, the number and capacity at which an area should be designated as overprovided is determined by the Board itself—there is not a uniform threshold against which areas are measured, nor is there a national 'example' or template overprovision statement from which LBs can draw [49]. Accordingly, LBs act autonomously to interpret availability-related evidence and establish local thresholds for overprovision as they see fit.

For example, ADP members reported their frustration in attempting to inform LB decisions regarding their Policy Statement and overprovision:

"You can put all the evidence and science in front of them that you like showing that link doing all you know, setting out the particular concerns you've got for parts of [LA1], chances are they're not going to take it on board."

(LA1, ADP Member)

This ADP member described working with other local licensing stakeholders to provide an evidence-informed report to the LB, which recommended certain local areas be labelled 'overprovided,' noting that this was unsuccessful given the autonomy LB members had to make the final decision. The existence of LB decision-making autonomy is supported by evidence of the variation in Licensing Policy Statements across Scotland [15].

The interview data also illustrated that LBs recognised and consciously used their existing discretion within the legislative framework. The quotation below is an example which illustrates how Board members spoke about their consideration of the relevant legislation, in which an element of discretion is also evident:

"The licensing laws ... they keep everybody tight on what way we should be going or what we can do or can't do or if we've got leeway in a certain place."

(LA3, LB Member)

This statement was made in the context of explaining how the LB had made a decision to change a local policy about licensed premise curfews. S/he explained that these types of decisions must be seen by the LB's legal team to ensure that local decisions are aligned with, or 'tight on,' national legislation, but that in this instance, the LB had the discretion, or 'leeway,' to make a decision regarding curfews. This demonstrates that interpretation and flexibility is present in the process of implementing the legislation. Evidence shows there are also specific personnel who help LBs to navigate the licensing legislation—legally qualified clerks which are mentioned throughout LA 2005 [50]. A similar, institutional support mechanism does not exist for other aspects of the Boards' public-administrative accountability, further indicating the dominance of legal accountability in the LB's accountability arrangements.

The flexibility within the licensing legislative framework seems to have been intentional on the part of the government. For example, in the cover letter of the associated *Guidance for Licensing Boards*, Gary Cox, Head of the Licensing Team states:

"I would like to stress that Boards will have the flexibility to operate and take decisions in light of their particular circumstances ... That is a fundamental principle of the [Licensing] Act, and it is

important to maintain it. The guidance does not seek to instruct Boards exactly how to make the Act work."

Guidance for Licensing Boards (2007) [48]

This purposeful flexibility gives LBs a significant amount of autonomy to interpret and implement the legislation. The findings from this research suggest that this flexibility has contributed to the limited implementation of the public health objective. For example, as will be discussed below, LB members often choose to prioritize local economic concerns (which are not enshrined in a licensing objective), presenting a potential challenge to the pursuit of public health goals.

When asked what sanctions would be applied if LBs were to diverge from their legal responsibilities, interview responses suggested that the primary fear was licensing decisions being appealed in court by the licence applicant, and that the cost of this would be significant.

"Well the Board's accountable. I mean, it's accountable by the reason that if it makes the wrong decisions, it ends up in court ... and costs the council, you know, £50,000, £70,000, £100,000 in the court case."

(LA3, LB Member)

By 'wrong decision', this interviewee is referring to a decision which can be legally challenged because it appears to be in error of the law or against the LB's Policy Statement. This legal challenge is the clearest mechanism of LB accountability (i.e., an LB may face consequences for their decisions) that was generated from the research findings. In this instance, a licence applicant (e.g., supermarket chain, or restaurant) or a licence holder (whose licence has been varied, suspended, or revoked) can appeal to the Sheriff Court, a civil court in Scotland [51]. In this system, LBs are held to account by the court as an organisation. This type of legal accountability is an important accountability mechanism which can prevent the abuse of public powers and which operates independently from the political process [52].

If a licence applicant or holder wishes to trigger an appeal of an LB decision, they can do so within 21 days [51]. In contrast, 'objectors' to an application (who may, for example, be a statutory consultee like the police/NHS or members of the public) are not able to appeal a decision [53]. Therefore, the same routes for triggering legal accountability mechanisms do not exist for objectors. There is therefore an inbuilt imbalance between the powers of licence applicants and alcohol policy implementers. Additionally, given the costs associated with mounting legal challenges, this system favours those with greater financial resources, and it seemed evident, from the interview data, that this informed members sense of where challenges were likely to originate from (and where not). For example:

"I think the Board ... has a lot of responsibility and a lot of authority that's pretty much unchallenged unless you can afford to go to a Sheriff to overturn a decision. I mean if ... we refuse alcohol in a BP [formerly 'British Petroleum Company'] service station, BP will take us to court ... But, small retailers won't, it's just not worth it"

(LA1, LB Member)

3.3. Flexibility Permits Licensing Board Prioritisation of Economic Considerations Over Public Health

The flexibility of LBs to interpret legislation discussed above was also evident in interview data which discussed local economic concerns. The way economic considerations and public health can come into conflict within Scottish alcohol policy has been noted in existing peer-reviewed literature [27], which this research complements by approaching the issue from an accountability perspective.

Multiple LB members discussed the need for licensed premises to contribute to employment and the economy, despite the absence of the economy being a consideration in the LA 2005 licensing objectives. For example:

"A lot of places ... they need their licensing outlets ... it's job provision. It's like having a factory, you know ... so that's the way you've got to look at it"

(LA3, LB Member)

These types of responses indicate that Board members' interpretations of the licensing legislation and objectives is flexible enough that they can take into consideration the (local) economy, even if this leads them to make decisions that go against the licensing objectives and increases the availability of alcohol in a given area. Other Board member interviewees displayed similar concerns: That the anticipated money and jobs that licensed premises might provide were considerations when they decided on a licensing application. However, LBs have a formal, legislative-determined responsibility for progress towards the public health objective and no formal responsibility for being concerned with the economy, and yet their concerns typically seem to be much more focused on the latter.

The tension between LB prioritisation of the economy over public health was explicitly discussed by one LB member. However, this was a minority voice among LB interviewees.

"I'm aware that other Board members have conversations about the economic impact of their decisions. Now obviously under the [Licensing] Act they're not supposed to take that into account at all, and I certainly try not to when I'm making decisions, but I know that other Board members do, and I've been told, for example, in the members' lounge, 'well, if that supermarket wasn't going to setup there then it would just be another empty unit for years to come and they're providing jobs anyway, so why on earth are you standing in their way?' I think that's a somewhat short-sighted approach and doesn't take into account a fair bit of evidence that suggests that adding another off-licence in an area that's already over provided for is just likely to make problems with alcohol and over consumption of alcohol worse."

(LA1, LB Member)

Recognition of this was also evident in national level interviews:

"[Licensing Boards] sit outside that local accountability. And I suppose the tension between the licensing objectives and what they see as their economic objective now licensing doesn't have an economic objective that it has for five licensing objectives, but they still see themselves as having an economic objective, and that probably provides quite a lot of tension."

(National Level 3)

This quotation suggests that some LB members have adopted a sense of accountability for pursuing economic objectives relating to perceived local needs and that this is felt more strongly than their obligation towards the licensing objectives, despite the legal framework attached to the objectives. It also suggests that this approach will be maintained as long as LBs are excluded from other local accountability structures (e.g., reporting to the local council). The problem with this tension is that, from the perspective of other local implementers, it challenges local alcohol policy implementation:

"Unfortunately a lot of our objections haven't met with much success, and the Board have granted applications that we've objected to . . . sometimes [licence applicants'] lawyers quote economic reasons, employment, and all of those reasons, whilst it might be a factor in the decision-making, it shouldn't really be because they should be basing decisions on the licensing objectives and the legislation."

(LA1, Police Representative)

The police are a statutory consultee on every license application and thus can file formal objections to any application. (Note, both police and a local area's Health Board are individual statutory consultees to the LB and, in this capacity, are permitted to lodge objections to applications). In the above, a police representative suggests that LB members have made licensing decisions based on information surrounding the economy or employment. These are not only unsupported legal grounds for licensing decision-making but may also come into direct tension with the licensing objectives and legislation (and existing public health research). Further, this person seems to suggest that these economic reasons are used by the LB to overrule local statutory objections to applications. This means

that economic considerations may be a threat to this mechanism by which local statutory actors can attempt to influence the restriction of alcohol licences. This is despite the existing *Guidance for Licensing Boards* stating,

“Commercial considerations are irrelevant to a policy which is designed to protect the wider public interest”

Guidance for Licensing Boards (2007) [48]

While formal guidance for policy action separates commercial considerations and public interest, it appears that the level of flexibility allowed to LBs within their legal accountability arrangements has created space for economic considerations to push aside public health concerns.

3.4. Lack of Accountability to Scottish Government

Data from both documents and interviews generated an understanding regarding LB accountability in relation to the Scottish Government. In the government’s *Framework for Action*, LBs are mentioned multiple times as contributors to reducing alcohol-related harm in Scotland, even more frequently than ADPs [2]. However, the language around holding LBs to account for these contributions is restrained. For example, the *Framework* states, “we will *encourage* local Licensing Boards to develop local solutions to address local problems.” (p. 14, [2], emphasis added). This inscribed language suggests that the government recognizes and perpetuates the autonomy of LBs, indicating in its communications that it must request, not demand, their cooperation in the whole-population approach to reducing alcohol-related harm. National level interview data also suggested the government was clear that LBs were not accountable to them:

“Licensing Boards aren’t accountable to Scottish Government. So we were not performance managing this across the whole system.”

(National Level 4)

This perception seems to have been clearly communicated to local level—nearly all LB members interviewed indicated they were not accountable to the Scottish Government. Further, LB interviewees reported that they did not perceive the Scottish Government to be actively monitoring their decisions or actions.

What is notable here is the tension between the Scottish Government’s role in defining Scotland’s approach to tackling alcohol related harm and the inability to hold a key set of organisations to account for contributing to this effort. If the Scottish Government is providing the mandate to pursue public health goals through the implementation of their alcohol strategy but cannot hold LBs to account for their role in this, then LBs will continue to be relatively free to prioritise other concerns. As an example, the quotation below highlights that the purpose of a national policy is nullified if LBs can simply ignore it.

“You can have a national policy up here, but if the Board’s just ignoring it, I’m not suggesting the Board is ignoring it, but we might sometimes ignore it, what will you do about it? You know I don’t think there’s any accountability to the Scottish Government to say, ‘So you can sit and make a big document to sit on the shelf all you want, but we’ll just ignore it.’ And what are you going to do about it. So, I’m not sure there’s any point in having a national policy document if Licensing Boards can just make their own minds up.”

(LA1, LB Member)

Again, the tension between LB members’ roles as Board members and as local councillors is evident. The Scottish Government has implemented legislation which places councillors on quasi-judicial, administrative boards but has not developed a corresponding system to hold them accountable for their actions on it. Further, it will be difficult for the Scottish Government to enact accountability over

councillors because it risks undermining local democracy. These results demonstrate that this particular gap in LB accountability constitutes a barrier to full alcohol policy implementation because it means LBs' responsibility for contributing to public health goals are not enforced by existing governance structures.

Additionally, this lack of LB accountability to the Scottish Government further distinguishes LBs from other alcohol policy implementers such as ADPs. For example, the *Framework for Action* uses stronger language surrounding the responsibilities of ADPs, including phrases such as “we expect decisions . . . ” [2] (emphasis added) when discussing the roles of ADPs. This suggests the Scottish Government feels differently (and less strongly) about the accountability of LBs to the government in comparison with ADPs. Additional interview data (beyond the scope of this article and will be reported separately) also demonstrated that ADPs perceive themselves to be accountable to the Scottish Government. Overall, it appears there are important differences between LBs and other alcohol policy implementers (i.e., ADPs) in terms of their accountability relationships with the Scottish Government, and that these differences seem to be led by national level. This is important because it reveals the variation in accountability arrangements across different alcohol policy implementation stakeholders, which may have implications for implementation processes.

3.5. Critique of Licensing Board Accountability

Within the interview data, critiques of the current licensing accountability regime were evident. Of greatest interest was that certain LB members were critical of their own accountability arrangements and advocated for greater consideration of public health outcomes by the LB. For example, two LB members from LA1 were particularly critical of current LB governance and accountability throughout their interviews. The quotation below discusses an LB member's issues with how their Policy Statement was developed:

“[The Licensing Board]’s not very accountable and it’s not very transparent . . . // . . . I have no great problem with people making decisions that I disagree with, but I do think they should be accountable for those decisions and at the moment they aren’t entirely”

(LA1, LB Member)

This quotation speaks to the issue of LB governance and transparency as it relates to accountability. It also raises the issue that if an individual or organisation wanted to hold the LB to account for the final content it puts in its Policy Statement, it would be difficult for one to do so. The quotation below demonstrates this:

“We pretty much make our own minds up, and that’s final. I mean [licence applicants] can appeal the decision in the Sheriff court, but, other than that, there’s no way to appeal to, to anyone . . . // . . . So, not to sound big-headed in any way, but I don’t think there is a huge feeling of accountability from Board Members to anyone in particular.”

(LA1, LB Member)

This quotation also illustrates the relative lack of checks and balances that influence LBs (with the exception of appeals when these are launched by applicants). In their interview, the LB member quoted above was critical of this situation, perceiving that the LB can simply ignore national policy and makes decisions about the development of their Policy Statement unchecked.

3.6. Lack of Public-Administrative Accountability to Local Governance Hierarchy

Transitioning to an analysis of LBs' public-administrative accountability within local-level governance, findings demonstrate Boards sit beyond local accountability regimes and lack local-level accountability.

“[The Board] has nothing to do with the other council structures. It’s a body on its own. It’s not accountable to anybody else in the council.”

(LA2, LB Member)

The above quotation is indicative of the consensus among interviewees that, at the organisation-level of public-administrative accountability, the LB is not accountable to the local council—it sits independently from the usual local accountability regime for local council committees.

Local and national level alcohol policy interviewees were critical of the lack of accountability of LBs to local governance bodies. In particular, there was recognition and frustration surrounding the inability of local public sector actors to hold LBs to account for work which affected other local organisations.

“Lots of activity at my level . . . working with the police and the [National Health Service], to try to influence the Licensing Board, nothing really happening, and then that frustration coming back at the Community Planning Partnership level because they can’t influence it either. So yeah, Licensing Boards, because of legislation, are sitting out here doing as they please without any accountability.”

(LA1, ADP Member)

Frustration was also expressed from national level stakeholders:

“Health is now one of the objectives of the licensing system, and health partners are statutory consultees. But that’s quite tricky . . . you’ve got locally elected members who sit on Licensing Boards, but the Licensing Board isn’t part of community planning . . . so you can have a Community Planning Partnership that say, alcohol’s a priority for us, and then you’ve got a local Licensing Board that basically says, who cares? You know, nothing to do with us, guv . . . so you’re ignoring the whole evidence base and there’s no accountability.”

(National Level 1)

This lack of accountability creates a barrier for effective achievement of alcohol policy goals, specifically the reduction of alcohol-related harm through the restriction of availability. The above quotation shows LBs can essentially ignore the goals and priorities of other local government entities, even when these priorities are directly related to LB decision-making (e.g., health as a licensing objective and alcohol problems as a local strategic priority). It also further shows LBs are able to make their own interpretations of existing public health evidence and have the autonomy to ignore it if they wish. This is problematic because it can create a tension between the LB and the broader policy context in which the national alcohol strategy and related local strategy planning have subscribed to this evidence.

3.7. Recent Changes to Licensing Board Accountability: Continued Need for Accountability Considerations

More recent legislation makes amendments to the existing regulatory regime surrounding LBs, which may have implications for their accountability. Specifically, relevant components of the *Air Weapons and Licensing Act 2015* (herein AWLA 2015) were developed following a 2012 consultation surrounding two main themes: Strengthening the powers of LBs and Police Scotland; and improving the effectiveness of the licensing regime [54]. It also introduced a mandate for LBs to report annually to the Scottish Government. Therefore, one might expect that accountability of LBs to the Scottish Government may change with more comprehensive enactment of the AWLA 2015.

A key component of the AWLA 2015 is the requirement of LBs to submit annual reports of their ‘functions,’ including a summary of decisions made by the LB, and a statement explaining how the LB has had regard to the licensing objectives [55]. In interviews, a Deputy Clerk for one LB was optimistic that this would enhance their accountability:

“You can have several months’ worth of [Licensing Board] business going by without much awareness, outside of what’s going on. And I think annual reporting, with specific information about the financial, you know, details of the annual fees coming in, details of what the fees are being used for, details of the numbers of applications, all of that. I mean, I don’t know, I think we’ll find out in due course, by way of regulation, what those annual reports will have to contain. But I think it’s a good thing.”

(Deputy Clerk)

The AWLA 2015 requires that the report must include statements regarding how the LB has had regard to the licensing objectives and their Policy Statement, as well as a summary about their decisions and the number of licenses in their area [55] (s.56 (2) (2)). However, although this section of the legislation was commenced in 2017, meaning the first reports were submitted in June 2018, the format and specific content of LB annual reports has not yet been published by the government [56].

Additionally, language in the legislation suggests that these requirements will have the same flexibilities as observed with other licensing legislation. For example, the AWLA 2015 states:

“A report under this section may include such other information about the exercise of the Licensing Board’s functions under this Act as the Board considers appropriate.”

(s.56 (2) (3), emphasis added)

This type of language suggests LBs will again be given significant autonomy in how they participate in this accountability reporting exercise, even regarding the type of information they wish to submit for scrutiny. Following Mark Bovens’ definition of accountability from the accountability literature [52,57], this type of statement, in which the potential ‘actor’ may use discretion to select what information they provide to the potential ‘forum’ (and thus what they have to explain/justify), undermines the possibility of establishing a robust accountability relationship between LBs and the Scottish Government.

Though the deputy clerk above was positive about this anticipated change, it was not always clear from interviews whether LB members were actually aware of this upcoming obligation. This indicates that the introduction of the annual reports was not communicated well to LBs, has not been prioritized by stakeholders in the licensing system, or both. This could further suggest that the stakeholders in the licensing system may not perceive the reports to be an important activity. For example, in LA3, multiple LB interviewees stated that they either had not studied the 2015 legislation yet or had only heard of it recently in a brief meeting discussion (despite these interviews having been conducted in late 2016). Overall, interviews with LB members indicated that the legislative changes were not yet implemented at the time of the interviews and did not suggest that there was any urgency to do so.

4. Discussion

The public health objective makes Scotland unique in its approach to licensing. However, the empirical results in this article suggested that LB members are not held sufficiently accountable for pursuing and protecting public health; a finding which emerged from analysis of the data. In particular, it was demonstrated that accountability mechanisms surrounding licensing do not currently allow for the objective to take its full effect. In starker terms, what has been observed is a tension between that which is written and suggested in the existing legal and policy framework surrounding alcohol licensing and that which is enacted in ongoing alcohol policy implementation practice, in terms of accountability mechanisms. The absence of a regular mechanism to ensure LBs are fulfilling their public health-related obligations means their decisions often present a challenge to alcohol policy implementation and the achievement of alcohol policy goals related to alcohol availability.

The concept of accountability was important here because it underpins how implementation occurs and is understood, as well as, importantly, who is (and how they are) responsible for undertaking implementation. The component parts of accountability processes—who is held responsible for policy implementation, how their actions are measured and judged, and how consequences are distributed—also provide insight into how governments perceive a given policy problem and its potential solutions. This article was concerned with the actions of public actors (i.e., those working in the public sector) who are often responsible for activities related to policy implementation [58]. What is known about accountability, and about the interplay of accountability with policy implementation processes, assisted the examination of how progress in Scottish alcohol policy implementation has been challenged or facilitated.

Thus, while the results presented in this article are aligned with existing research suggesting the public health objective has been difficult to implement [14,27], they also suggest that the lens of accountability is an important component of explaining why implementation has been challenging thus far. They lend support to an analysis which is focused on the accountability mechanisms surrounding licensing decision-making and its relationship with alcohol policy implementation.

4.1. Legislative and Legal Tensions

While a legal accountability system exists to regulate LBs, the arrangements are not conducive to protecting public health interests. As they stand, these arrangements do not adequately support the implementation of the public health objective (despite it being a component of the legal framework), creating a missed opportunity for supporting the implementation of the overall Scottish alcohol strategy.

To analyse this further, the data showed that public-administrative accountability of LBs relies on legal accountability arrangements; beyond legal accountability, there is a lack of other public-administrative mechanisms for holding LBs to account. This creates challenges for alcohol policy implementation and the pursuit of public health goals in this process, because any gaps or failures within legal accountability processes to support alcohol policy implementation cannot be mitigated by other public-administrative mechanisms. Indeed, while LB accountability is reliant on legal mechanisms, the practical arrangements of this are characterised by substantive flexibility and an imbalance towards wealthy industry stakeholders.

This leads to two observations. First, LBs' flexibility to interpret legislation may allow them to contextualise the legislation ('in light of their particular circumstances'); however, this also leaves them free to interpret the licensing objectives more flexibly than intended or to even ignore the 'spirit' of the legislation which seeks from LB members an understanding and concern about public health impacts of availability. This finding is aligned with results from a review of LB Policy Statements by Alcohol Focus Scotland, which showed that overprovision statements were varied in their breadth and strength [15], suggesting interpretative flexibility of availability-related evidence. This analysis also reaffirms research which finds that discretion among LBs can lead to inconsistent policy implementation [28].

Second, the observed imbalance towards wealthy licence applicants suggests LBs are only held to account by applicants who have the financial resources to challenge their decision-making on a legal basis. While the court case regarding MUP positioned the alcohol industry as an adversary of the government and its public health goals [59], the accountability structures and practices surrounding alcohol licensing continue to favour large industry retailers and largely exclude public health stakeholders. If this is the only mechanism that is effective for holding LBs to account, this excludes (a) alcohol policy implementers such as ADPs and their member organisations from holding LBs to account, because they cannot engage in the system in this manner, and (b) less financially secure licence applicants. The imbalance in this power distribution favours economic actors which also control significant financial power and resources, namely large industry producers and retailers. This creates a system in which powerful industry actors are also the actors who are most empowered to challenge the system that exists to regulate them. These findings are aligned with existing research in which public health actors perceive licensing processes as unfair, disempowering, and favouring of well-resources licensing actors [28]. Further, it is unlikely that this accountability mechanism will lead to the prioritisation of public health goals—it is located in the justice, not health, portfolio, and its imbalance towards large industry stakeholders means that the key interests of these stakeholders are also likely to be in conflict with public health objectives (i.e., industry is unlikely to trigger an appeal in pursuit of better public health-related outcomes). These findings are also aligned with a discussion of legal accountability in the broader public policy literature by Hill and Varone, where they highlight that the "law may be comparatively impotent in the face of complex issues of administrative discretion," and that these concerns about the limits of legal control "stimulates a search for other models of accountability" (p. 344, [60]).

Thus, there is a tension in that, while licensing is meant to regulate alcohol retailing and availability, in practice the system still privileges large retailers. This problem is possibly perpetuated by the way the licensing system is currently meant to traverse multiple policy systems, i.e., justice/legal and public health, which have different approaches and priorities. This suggests that there is a need to effectively utilise systems of accountability to mitigate differences between these sectors, whereas, currently, they may be serving to perpetuate them.

Ultimately, the reliance on legal accountability of LBs and the characteristics of the enacted processes contribute to the tension between what is formally included in relevant alcohol licensing legislation and policy and what is observed in practice.

4.2. Democracy, Accountability, and Public Health in Scottish Alcohol Licensing

This analysis also highlights contextual and situational factors which further contribute to the identified tension. This included characteristics of local democracy, in particular in the roles of locally elected councillors and in the relationship between Scottish and local governments. The first example relates to the interplay of local democracy, accountability, and the economy. The data suggested that while LBs have a formal responsibility regarding the public health objective and no formal responsibility for being concerned with the economy, they often exhibited more concern for the latter. This could be a function of their simultaneous status as elected councillors and as LB members. As councillors, they have a responsibility for the economic wellbeing of their local area because they have been elected by their local community, and because the Scottish Government's National Performance Framework demands that local government have regard to the government's Purpose of economic growth (note, an updated 2018 version of the National Performance Framework states both 'increased wellbeing' and 'economic growth' as the foundational components of the government's Purpose [17]). However, LB members legally have responsibility for public health, not economic concerns—the document guiding their decision-making states that commercial considerations are irrelevant to a policy which is designed to protect the wider public interest. Therefore, it is observed that their simultaneous roles of elected councillor and LB member seem to be in conflict, and that their democratic accountability and legal accountability are also in tension.

It is important to note that concerns regarding employment and the economy are relevant for health policy, particularly through a social determinants of health perspective [61,62]. It would be unwise to dismiss these concerns as irrelevant in this context—existing research has demonstrated, for example, that factors related to employment are associated with general health and mental health outcomes [63]. Interestingly, however, LB members did not frame their economic considerations in this way in interviews, even though this may have provided justification for their otherwise informal concerns. Instead they portrayed their concerns with employment and the economy as standalone and self-explanatory.

A second component of the analysis related to local democracy observes the differences between elected and non-elected alcohol policy implementation stakeholders. It was observed that councillors will experience democratic accountability which local, non-elected policy implementers (such as members of ADPs) will not. In light of this local political context there is a tension in how alcohol policy implementation is governed. Elected councillors are not part of the same systems of accountability as non-elected local government actors. However, the National Performance Framework identifies health as a Scottish priority, and LBs have a direct influence in contributing towards the alcohol-harm-related goals of the National Performance Framework because they control the availability of alcohol. It appears that their role as a LB member is again in tension with this councillor role, because being a LB member is a policy-led, administrative position which is explicitly intended to contribute to central government goals around alcohol-related harm [49], and one would presume that they should, as such, be held accountable for this policy work. Yet, this research identified no obvious mechanism through which LB members were held to account for this work. In light of these local contextual tensions and factors, local politics and councillors' democratic accountability need to be acknowledged as

important considerations underpinning LB accountability processes, with implications for alcohol policy implementation. This is a topic on which Fitzgerald and colleagues [28] have also made an important contribution, and this article complements that work by including non-public health interviewees (including LB members themselves) in a smaller number of local areas, allowing for an in-depth analysis specifically regarding public-administrative accountability surrounding LBs.

Third, LBs have a different arrangement of formal public-administrative accountabilities than other alcohol policy implementers, who are subject to more explicit accountability and reporting mechanisms within local and national governance systems. These differences are important because, as a consequence, LBs have greater discretionary powers and are subject to less oversight than other local policy implementers (e.g., ADPs). For example, LBs are quasi-judicial bodies which sit independently from the established accountability regime for other local council committees [64]. Thus, although LBs make decisions which influence the local populace and may impact local government progress towards their own strategic priorities, they sit beyond the accountability arrangements which could monitor them. This is potentially problematic because, if their actions present a barrier to the achievement of local strategies, local actors do not have any recourse to hold them to account for this. This demonstrates a key aspect of the LB accountability problem for alcohol policy implementation: While LBs sit beyond the system of public-administrative accountability applied to other alcohol policy implementers, they will continue to present a key challenge to achieving availability-related alcohol policy goals. If different stakeholders, who are meant to be allied and working towards shared policy goals, are not subject to similar accountability mechanisms, then there is a risk their actions diverge from one another, and possible come into conflict.

To illustrate this further, local authority areas have Local Development Plans which outline their visions and strategic priorities for their local communities [65]. These often include priorities around health and wellbeing. As a clear example of this, one region in Scotland, Aberdeenshire, has recently named 'Changing Aberdeenshire's Relationship with Alcohol' as one of three local priorities for 2017-2027 [66]. In this context, implementation of a local strategy and the achievement of its intended alcohol-related outcomes will be challenged if the local LB acts with relative impunity to increase alcohol availability.

Finally, the data suggested that the Scottish Government is noticeably absent as an accountability forum for LBs, a situation of which many interviewees were critical. This current lack of accountability to the Scottish Government is problematic—if LBs are perceived as contributors to Scotland's alcohol strategy, there must be a mechanism to ensure they act in this capacity, and the government is well-placed and legitimate to do this. However, it was noted that this would be complicated by the different levels of democracy at play, which influence LB members' actions and have implications for whether the Scottish Government can hold them to account for their role in alcohol policy implementation. Despite this, the Scottish Government may be a well-positioned and legitimate organisation to shoulder both monitoring and accountability of LBs if this was arranged to be coherent with local autonomy and democratic accountability. Given the critique of the current situation by national and local alcohol policy stakeholders (including LB members) from a public health perspective, it will be important (and possibly timely) to push for system change.

4.3. Implications for Research and Policy

In light of the findings reported here and the knowledge gaps that remain, it is recommended that future research examine other aspects of accountability experienced by policy implementers. For example, this may include examining horizontal accountability(ies) to professional colleagues or a more nuanced analysis of perceptions of accountability to the public. Additionally, empirical analyses of how accountability regimes are aligned or conflict with other aspects of alcohol policy implementation processes will be needed if comprehensive understandings of implementation are to be attained.

Further, while existing alcohol policy implementation literature has included different considerations of accountability, there is a dearth of literature about alcohol policy which examines

how, why, and in which circumstances different accountability mechanisms may be most effective. In terms of both research and policy implications, there therefore appears to be a need both to explore with stakeholders what alternative approaches to LB accountability may be effective and to develop a research agenda which investigates them empirically. As a first step, the findings reported here suggest introducing a monitoring system of LB licensing decisions (including whether objections were lodged by statutory consultees), which may provide useful data to inform future research and decision-making.

4.4. Strengths and Limitations

The combination in this study of interviews and document analysis permitted a timely, in-depth analysis of the interplay between accountability mechanisms and alcohol policy implementation in the context of Scottish alcohol licensing. However, local interviewees in this research were drawn from a subset of three local authority areas in Scotland; therefore, it is not possible to make broad generalisations nationally or internationally. Further, space did not permit discussion of other types of accountability which arose in the data as possibly impacting alcohol policy implementation—accountability within the LB itself or in relation to public involvement in licensing, for example.

5. Conclusions

In the context of limited empirical alcohol policy research which examines the interplay between alcohol policy implementation and accountability, this article makes a contribution to understanding how accountability processes influence the effectiveness of alcohol policy implementation in Scotland. In the case of Scottish alcohol licensing and the ‘public health objective,’ it was argued that there is a tension between the intentions of licensing legislation and the way it is enacted in practice. In particular, it suggests that there are a lack of accountability mechanisms acting upon Scottish LBs to ensure they contribute to the public health goals of the Scottish alcohol strategy. From a public health perspective, this has perpetuated a system in which LBs continue to act with problematic levels of flexibility and autonomy from the rest of the alcohol policy implementation system.

This article does not claim that Scotland’s alcohol strategy or, within licensing, public health objective itself has failed. Instead, it suggests that the implementation of these policies is suffering from challenges that are well-known in the wider policy implementation and governance literature: That it is insufficient to develop public health policy or legislation and expect that the implementation of this will straightforwardly follow from this top-down decision. In this case, this problem is particularly acute given the complex interplay of public health, economic, democratic, and governance concerns which influence the decisions and actions of alcohol policy implementation stakeholders. The key message, however, is that national alcohol policy in Scotland will fall short of intended goals as long as the tension between licensing legislation and enacted licensing practice remains.

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